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RELIGION AND MENTAL HEALTH*

REVEREND JAMES VANDERVELDT, O.F.M., Ph.D.
Catholic University, Washington, D. C.

IN 1948 a committee of psychiatrists and representatives of the various religious denominations was formed in New York under the auspices, and with the financial support, of the then existing National Committee for Mental Hygiene for the purpose of discussing the relationship between religion and mental health. The committee met quite regularly for over a year under the able chairmanship of Dr. Harry Tiebout.

The main advantage of our meetings was that the much-talked-of problem of relationship between religion and mental health was put on a practical footing. Our meetings seemed to show that the participants did not consider religion as a mere illusion, for if religion is just an illusion, it would be rather illusory to start discussions on its value.

A peculiar stumblingblock in some of our discussions was the language. We all spoke English, but semantic differences occasionally handicapped the mutual understanding between the psychiatrists, particularly the analysts, and the clergy. Let me frankly confess that from my little corner I watched with fascinated interest the reactions of our psychiatric friends in some instances when a representative of religion presented a term that had a familiar ring for them. In order to avoid mutual misunderstanding, the suggestion was made that it might be a good thing to draw up a vocabulary or glossary or nomenclature in which the psychoanalytic language would be translated into religious terms, or the other way

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around. As a matter of fact, an attempt has recently been made to do just that. The English author, B. G. Sanders, a confessed "religionist" who believes in the existence of God, published an essay in which he made an attempt to "translate religion into the new language."[1]

To our way of thinking, the attempt is well-nigh hopeless. There are not only various interpretations of one and the same concept among the different types of religion, but we know also that the different analytical schools give a very different connotation to psychiatric concepts. Besides, we should not forget that the psychoanalytic language is not, even among psychiatrists, the lingua franca.

The tendency to translate religious experiences into analytic language also came to the fore in our committee. One of the members, M. R. Sapirstein, M.D., drew up what he called a chart, comparing point for point what psychology does or can do for mental health and what religion does or can do. This chart proved most helpful in channelizing the discussions, but the majority of the members did not seem too well satisfied with it. For one thing, the chart was too analytical; when you cut a system into pieces, you may easily kill the spirit. But the main reason for the dissatisfaction was, as I see it, that the concept of religion as presented in the chart was unacceptable to several of the members. And here we come to a crucial point.

It would be ostrich policy to deny the fact that a certain vagueness hovered over our discussions. One could notice, in the first place, a certain confusion about the respective rôles of ethics and religion. The two are not identical. True, every religion worth the name includes a body of moral principles which it presents to its followers as the rules that should govern their moral conduct. On the other hand, an ethical system is not necessarily a religion, unless one wishes to give special interpretation to the term religion. And the interpretation of the term religion was precisely the other, and main, source of confusion.

It is pretty useless to speak of religion in general, not only because there are several types of religion, but principally

[1] See *Christianity after Freud*, by B. G. Sanders. London: Geoffrey Bless, 1949.

because the term, religion, is used at the present time with two entirely different connotations. I mean theistic and non-theistic religion. Here lies the principal demarcation line.

What do we mean by theistic religion? Leuba, in 1914, set forth some forty-eight different definitions, and many more have been added since then. Most of these definitions are tendentious in as much as they reflect the author's own concept of religion. Here is one that seems to be free of that evil and that covers all the different kinds of theistic religion: "Religion is the sum-total of beliefs, rules of conduct, and rites governing the relations of man with a Power or Powers looked upon as transcendent."[1]

All theistic religion recognizes some supreme Power or Powers, God or Gods, who transcend man. Non-theistic religion refuses to recognize such a transcending Power, but, instead, professes that man takes the position of central and supreme importance; hence, some speak of humanistic religion. The question whether non-theistic religion and humanistic religion coincide or not, seems to be of minor importance at this moment. But one might well ask whether the term, religion, is still in order when used in this way. For, indeed, non-theistic religion might be called a philosophy of life, a *Lebensanschauung,* but the claim that it is a religion seems to be as confusing as the claim of the Russians that they, too, have democracy.

However, we are not interested at this point in the right or wrong application of terms. I wanted only to show the demarcation line. I do not maintain that a humanistic philosophy of life can contribute nothing to mental health, for such a philosophy, if it embodies a set of moral principles that are in accordance with the natural law, may very well be beneficial to man's health. But that a humanistic philosophy possesses a positive value does not in the least mean that theistic religion has a negative value.

Although Freud was allergic to all religion, it may well be that he would have found little difficulty in accepting this kind of religion, for it agrees with his atheistic philosophy.

But all this is beside the point, because Freud's number-one enemy, theistic religion, is still very much alive. Since we

[1] "*L'Etudes des religions,*" by L. de Grandmaison, in *Christus, Manuel d'histoire des religions,* edited by J. Huby. Paris: Beauchesne, 1913. pp. 6–7.

are standing on its side of the fence, we may ask: Does theistic religion have any mental-health value? Freud's answer was no. To him religion was not only an illusion, but also a dangerous enemy because, in brief, to his mind religion makes weaklings out of people.[1]

Freud's fear of danger seems to be slightly exaggerated, to say the least. Long before Freud, millions of people professed very theistic religions, but were, on the whole, no more neurotic than Freud. Their strength and powers did not seem to be paralyzed by their obedience to God. And it would be a pretty gratuitous statement to maintain that all those millions who "survived" their belief in God were humanists and not really "religionists." We might quote here Jung's statement, made in 1932 before a group of Protestant ministers at Strassburg, in which he expressed an opinion that is the direct opposite of Freud's: "It seems to me," he said, "that the increase in the number of neuroses has paralleled the decrease of religious life."

Freud's exaggerated position is contradicted by many analysts, who no longer hold that belief in God is an illusion or a danger. The Viennese analyst, Victor Frankl, says that many analysts no longer worry in the least about the future of an illusion, but that they have started thinking about the eternity of a reality.

One of Freud's objections against religion was that it teaches dependency on God—as, indeed, it does. But Freud and his followers feel that this dependency is not a desirable attitude; for them, the supreme good of psychiatry should be to make the patient a mature, independent, self-sufficient person. However, at the present time, a sizeable number of psychiatrists have begun to realize that independence and self-sufficiency may be just as unhealthy and neurotic as some forms of dependency. Here I wish to quote M. R. Sapirstein who—as I stated before—was one of the members of our committee. "More and more psychiatrists seem prepared to accept the dependencies of *religion*, social causes, and group movements, as healthy and needful, without labeling them

[1] See his statement in *New Introductory Lectures on Psychoanalysis* (New York: W. W. Norton Company, 1933, p. 205): "Of the three forces which can dispute the position of science, religion alone is a really serious enemy."

'sublimated homosexuality' to a father figure, or a desire to return to the mother's womb."[1]

This is the opinion of a non-Catholic. We Catholics hold that the dependency on God is a healthy one, because it prevents the individual from becoming unduly attached to, and therefore dependent on, himself, other persons, and things. On the other hand, dependency on God, according to the Catholic doctrine, does not make a weakling out of man, because it teaches very emphatically that God helps those who help themselves: *"Facienti quod in se est, Deus non denegat gratiam."*

What are the positive contributions of theistic religion to mental health? Some excellent suggestions were made by several members of the committee.

In the first place, the theocentric plan of life teaches man the meaning of life and his own destiny, because it provides him with an end, a purpose, a motive, an object in living. When a person knows what he is living for, he can accept his lot with patience and contentment, and consider it as something worth while. Even though he may play only a very secondary rôle in life, he can easily endure the hardships, emotional crises, disappointments, and monotony of life.

Perhaps some one may say that non-theistic religion, too, is able to give a meaning to life and to outline for man his destiny. My answer to this is a repetition of what I have already said: we are standing on this side of the demarcation, and it is not for us to decide the problems that may arise on the other side of that line.

In the light of his own human destiny, religion teaches a person to accept frustrations and suffering; the individual who is aware of life's basic meaning may see that even suffering serves a purpose, and thus becomes a constructive element.

Does religion take away life's disappointments, difficulties, perplexities, drudgery, labor, and duress? Certainly not. But it teaches the individual endurance and resignation, because religion—and religion alone—gives him the answer to the perennial problem of the nature of evil and sorrow.

One who does not know why there is evil in the world, and

[1] *Emotional Security*, by M. R. Sapirstein. New York: Crown Publishers, 1948. p. 82.

why so much hardship befalls him personally, is liable to collapse and fall into depression and eventually he may be driven to suicide. For those who are tortured by the problem of good and evil there is only one alternative—an alternative of which we find a striking illustration in the life of the French writer, Joris Karl Huysmans, who in final despair embraced Satanism, the religion of the devil, and of whom his friend, Barbey D'Aurévilly, had this to write: Only one choice is left to Huysmans, the choice between the revolver and the crucifix. Huysmans chose the crucifix.

Religion teaches us not to make a show of sorrow, and in that respect it may help to prevent a person from turning into a hysteric. Religion teaches a man to surmount his egocentricity, and by the same token it provides for a basis of satisfactory interpersonal relationships, because respect for persons is grounded in faith in God, instead of in merely human sentiments and changing mores.

Finally, religion is effective in the implementation of moral standards and gives the individual the reasons why he should conform his conduct to those standards.

These were some of religion's main contributions that were considered beneficial to mental health. Of course, there is nothing startling about all this, but at times it seems useful to reiterate the obvious, when the obvious seems to be denied.

As soon as moral standards were mentioned, the psychiatrists of our group cocked their ears, and a rather lively discussion ensued concerning sin and guilt feelings.

At this point a question was asked, dressed in the form of a syllogism that ought to figure as a classic in the textbooks of logic. Sin—it was said—implies lack of perfection; but a sense of perfection is undesirable; must we, therefore, conclude that sin is desirable?

Without disentangling the syllogism—we leave that up to the logicians—suffice it to say that sin is always undesirable. But a person's realization that he has committed a sin may well create in him a feeling of humiliation; it shows him his imperfection and limitations. And in that manner sin, although itself an evil, may produce good results.

The fact that some members of the committee were of the opinion that all guilt feelings are undesirable while others thought that *some* guilt feelings can be made constructive,

seemed to indicate that some confusion exists about the concepts of sin, guilt, and guilt feelings. Allow me, therefore, to set forth our Catholic standpoint. Sin and feeling of guilt do not parallel each other. Sin is a violation of the moral law and, therefore, an offense against the supreme Law-giver. Sin supposes full consciousness. This is an important point, because it means that there is no such thing as an unconscious sin; a purely material deviation from the law, not adverted to as such, is no sin. If one has committed an objective sin, one is guilty; yet the feeling of guilt is a subjective phenomenon. As a feeling, it is evidently conscious, although it may be vague or confused. But such a feeling may be the result of conscious, as well as of unconscious, factors. When a person commits a sin, he knows full well why he feels guilty. But the source of guilt feelings may also be unconscious; in other words, an individual may feel guilty where there does not seem to be any apparent sin.

With this distinction in mind, our answer to the controversy to which we alluded would be this: guilt feelings caused by a conscious sin are a natural phenomenon and desirable, because they motivate a man to see his own inadequacy; but the guilt feelings that stem from an unconscious source are undesirable. Now, religion plays a rôle only in respect to the first type of guilt feeling—that is to say, those that are the result of a conscious sin.

When we observe the interest that many psychiatrists reveal as soon as the problem of sin arises, we may perhaps ask the question: Is the psychiatrist, then, a moralist? The German psychiatrist, J. N. Schultz, rightly warns the psychotherapist not to set himself up as a peddler in philosophy, a pastor substitute, a schoolmaster, or a moralist. Of course not, because the psychiatrist is a physician and must proceed accordingly. But if the psychiatrist is not, and should not be, a moralist, what, then, should be his attitude toward sin? The question is important, because there seem to exist some wrong ideas about it. Sin in the sense of an offense against God should be treated in the Confessional, but not in the studio of the psychiatrist.

Let me make this clear by a comparison. When a physician treats a syphilitic, he will do so without moralizing about the patient's previous conduct, which has caused the sickness.

However, after the man has been cured, the doctor might perhaps give him a bit of human advice for the future—at least if he has at heart the patient's well-being and not his own pocketbook. A similar condition exists when the psychotherapist is treating a mental case. Suppose that certain activities which ethics calls sinful have made the patient what he is, a neurotic. During the treatment there will be appraisal of the conflict and of the motivations underlying the man's actions, but there will be no appraisal of those acts from the moral standpoint. However, it may be found that in these cases, too, "a bit of advice" will be extremely helpful for the patient's future life. For it is highly questionable whether analysis alone is sufficient to make, for instance—as Liebman suggests—an exemplary husband out of an adulterer, without telling him "what to do or how to act." Analysis may have given him an insight into the reasons why things are wrong with him. But is this insight enough to restrain a patient from repeating the same mistake that brought about his neurotic condition? This is one of the most serious of the questions that face psychiatry.

Those who believe in the inner-release therapy in its extreme form will see their task as that of fully bringing to the surface all the ramifications of conscious and unconscious material of the patient's mind, and when this has been done, will consider their task terminated, leaving it up to the patient to decide what he is going to do about it from then on.

However, this neutral-attitude therapy is meeting, at present, with serious reservations. Here, allow me to quote once more Dr. Sapirstein, who says: "Unfortunately for the average patient, the mere understanding of where his machinery has broken down and what his internal conflicts are may not be sufficient to cure all his difficulties. He may find that although he understands what is wrong with his interpersonal relationships, he is still unable to change."[1]

These words imply, of course, that in the case of the average patient, it may be advisable for the psychiatrist to help him to outline for himself a new or better plan of life—a procedure that Kronfeld, in Germany, long ago called the psychagogical or psychosynthetic method. A further implication is that if

[1] M. R. Sapirstein, *op. cit.*, p. 252.

the patient's condition has a moral or religious undertone, that better plan of life should contain more constructive moral or religious elements. Hence, here again religion comes in. And at the same time the question arises how the psychiatrist is to make use of religion. This question was brought up several times before the meeting, but it never was fully discussed. Nevertheless, although the problem is seemingly methodological, it touches on very fundamental points. Allow me to give you briefly my answer.

It would, of course, be unfair, to say the least, to impose or even to insinuate any kind of religion that is not in agreement with that of the patient. The psychiatrist who, consciously or unconsciously, would suggest his religious ideas to his patients would trespass the limits of his competence. No one would call it permissible for a Catholic psychiatrist even to insinuate his convictions to a non-Catholic patient. This is so obvious that it scarcely needs arguing. Such a procedure not only would be unfair, but it would not serve any curative purpose, because it would probably only further confuse the patient. Imposed religion is no religion. But then we may expect the same rule to hold for any other psychiatrist, regardless of whether he calls his philosophy of life religious or not. In other words, the rule holds also for those who profess the "new religion"—that is to say, the non-theistic, humanistic, or man-centered religion, or whatever one wishes to call it. Theoretically, this principle is obvious, but in practice? Perhaps it might be a good thing for some psychiatrists to examine their conscience or, if they prefer another term, their super-ego—on this score.

All the therapist could and should do is to assist the patient in formulating a plan of life that is in accordance with his own personality structure. In simple words, a psychiatrist who deserves the name of psychotherapist must be able, through analysis and observation, to penetrate into the patient's personality and help him to discover in himself the constructive potencies, ideals, objectives, and aspirations that will make his life worth living. In other words, the psychiatrist must be able to revive in his patient values, regardless of whether these values are above the level of consciousness or hidden in the depth of his unconscious. And if the psychiatrist approaches his task without prejudice,

more often than not he will also find in his patient values of a moral or religious order.

At this juncture I may quote from Blaise Pascal words that have stuck with me ever since I read them: "*Il n'y a que deux sortes de personnes qu'on puisse appeler raisonables: ou ceux qui servent Dieu de tout leur coeur, parce qu'ils le connaissent, ou ceux qui le cherchent de tout leur coeur, parce qu'ils ne le connaissent pas encore.*" ("There are only two kinds of men that can be called reasonable: those who serve God with all their heart, because they know Him, and those who seek Him with all their heart, because they do not yet know Him.")

Of course, in case the analyst does not find anything that even remotely resembles religion, it would be perfectly useless to try religion. Religion has a therapeutic value only for those who either have sincere religious convictions or manifest a desire for them. Religion is not just a pair of galoshes which one puts on because it happens to be a rainy day.

However, when dealing with a patient, let us not claim too soon that he does not reveal any religious aspirations. In this respect, I wish to refer to the remarkable work done by the existential analysts. Even when treating persons who profess to be decidedly irreligious, the existential analysts find what they call "unconscious religion." They are convinced that in many cases emotional disturbances are due precisely to unconscious or repressed religion. Their standpoint is that of Freud, but in reverse order. Where Freud says that religion is the universal compulsive neurosis of humanity, the existential analysts maintain that compulsive neurosis is often diseased religion, and they give numerous examples of case histories to bear out the statement. On the basis of analysis and dream interpretation, they find deep down in the patient's unconscious the voice of conscience and a longing for God, even in the case of manifestly irreligious people. All the psychiatrist should do is to wait until the latent religious elements within his patient break through spontaneously. If the patient then wants more advice about things religious, the analyst may refer him to the priest or minister.

During our discussions more than once the question was raised whether psychiatry could not contribute all that religion

has to offer. Of course, there is little comparison between the two from a simple pragmatic and quantitative standpoint, for religion is for the millions and psychiatry for the few who can pay a handsome fee. Apart from this somewhat naughty remark, let us compare the relative contributions of the two with regard to mental health.

Psychiatry, including any type of depth therapy, offers methods and techniques for the treatment of the mentally ill. In that respect religion is no substitute for psychiatry, for the simple reason that religion—at least most kinds of religion—is not a medical system. Religion primarily aims at bringing people closer to God and by doing so it may secondarily promote the people's mental health. And this secondary task is mostly of a protective, preventive, and safeguarding nature.

When treating persons with a serious mental breakdown, the psychiatrist may make use of the individual's religion, but he should realize that religion offers certain things that psychiatry itself never can give. Let us limit ourselves to two points: Religion alone—I repeat, theistic religion—can give what the Germans call the *"ruhenden Pol,"* the firmly fixed Pole, the Absolute. When God holds the central place in one's life, life's perplexities and emotional crises become relatively unimportant. Now, no psychiatry can give God to a patient, unless that patient has already serious religious convictions. But there is more. People who have such convictions believe that God assists them in a very personal way. This belief is found among Catholics and Protestants alike and is far from uncommon among the adherents of non-Christian religions. This assistance is called divine grace, and no psychiatrist can give grace to his patients. Many a psychiatrist will shrug his shoulders and say that he does not know what that means. This may well be true, but ignorance gives nobody the right to refer to grace as an illusion. One might perhaps remember Shakespeare's caustic words: "There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy." Regardless of what grace may mean to others, the fact is that it is a very real thing in the mind of the faithful and that it plays a very real part in their lives.

Avoiding theological discussions and distinctions, let us describe in a simple way what we mean by supernatural grace,

so as to make the concept, if not acceptable, at least understandable. Grace is a supernatural gift of God to man, destined to make him achieve his salvation. This divine assistance illumines a person's reason so that he may see more clearly what is good and what is expected of him, and it strengthens his will, so that he may more readily fulfill his obligations.

Many people may not have a very clear idea about grace, but every one who is convinced of his theistic religion possesses the basic concept that God helps him in a special way, particularly in time of need, stress, strain, and emotional trouble. This very idea that "God will help me to overcome even that" contributes greatly to produce in the individual a sense of trust, strength, resignation, and submission, and, if necessary, to start a change of life.

An illustration may clarify what we might call the psychodynamics of grace. It should be understood that supernatural grace does not substitute or destroy the natural powers and functions of man, but—so to say—builds on them. Let us take the condition of a person during or after prayer, when—so the saying goes—he "feels better." He may see his difficulties in a different light; he may feel deeply sorry for his sins and thereby feel reconciled with God; he may feel a greater love for God; he may see the importance of things eternal and by the same token the relative insignificance of earthly things, including his sufferings; his hope may be strengthened, so that the future looks brighter; he may feel resigned to accept whatever comes to him; and so on. All these thoughts, desires, will-acts, and aspirations have a reassuring, uplifting effect, even when we look upon them from the purely natural standpoint. But we hold that God may influence the soul of a person in prayer in such a way that he not only experiences these thoughts and aspirations, but experiences them in a higher and more efficacious degree. And everybody will agree that such aspirations have a beneficial effect on one's mental condition, and, according to psychosomatics, also on one's physical well-being. We find a good example in the alcoholic who, when in the morning he asks the Lord to help him to stay sober just that day, is convinced that if he succeeds, he will owe it to God's help. And to the alcoholic this is not an illusion, but a very real thing.

In conclusion, we may sum up the relationship between religion and mental health as follows:

Sincere religious convictions are a powerful therapeutic aid to the preservation of mental health, but they do not constitute an infallible panacea.

Religion is no substitute for psychiatry. If a person's mental health has broken down, pious exhortations alone won't restore it, but religion may well provide a better plan of life in the future.

Psychiatry is no substitute for religion despite the attempts of some "new religionists."

MENTAL-HEALTH OPPORTUNITIES IN THE GENERAL HOSPITAL*

WILLIAM H. DUNN, M.D.

Associate Professor of Clinical Psychiatry, Cornell University Medical School, New York City

THERE would seem to be no need to-day to argue either that there are opportunities to be found in any general hospital to strengthen mental health or that we should take full advantage of such opportunities. The impact of the emotions on physiologic functioning and organic disorder has become recognized by surprisingly large numbers of the general public, including our patients, by large organized sections of the community, and by most physicians. Recognition and acceptance by the layman of the importance of the emotions in medical practice is the result of long-enduring, persistent work by mental-health agencies, assisted by such media as newspapers, magazines, the radio, and the movies.

It is probable, too, that the psychiatrist in military service had considerable effect in reinforcing this greater acceptance of psychosomatic factors on the part of his patients and their families, in spite of the jaundiced view of his efforts so often expressed by these individuals at the time of treatment. Being forced out of our seclusion by the military service also brought home to our medical colleagues the fact that we had something to offer outside our consulting rooms and psychiatric hospitals. In addition, medical men from the most varied fields of practice and from all over the country had experience in military general hospitals where psychiatric services were available.

Whatever the reasons, there has been steady growth in the demand for psychiatric service in the general hospital. For instance, in the Payne Whitney Out-Patient Clinic of New York Hospital in 1932, about 30 per cent of our referred cases came from other clinics and services in the hospital. To-day that percentage is approximately 70 per cent. The only ex-

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planation for this that seems valid is increased awareness, in the house and attending staffs, of the emotional factors in the problems of their patients. There can be no doubt of the growing awareness in the medical profession and allied services of the importance of considering patients as persons and not just as cases; of studying the patient's total personal problems, not just the immediate, presenting physical disorder. But many physicians who have this understanding neither feel adequately equipped to act for themselves nor do they know to whom to delegate situations that involve their patients' psychic, environmental, and social problems. The social resources of their own communities are often completely unknown to them or acknowledged and used only with resistance. However, it is now known that psychiatry does attempt to cope with such situations. Pressure from the community, which includes the hospitals and their staffs, is on us and we are struggling to preserve a new-won status as well as to meet very real and very great human needs.

In this survey of our work in the general hospital, an attempt will be made to comment briefly on the organization and work of the psychiatric outpatient clinic, on the contributions of the consultant in the general hospital in his work directly with patients and in his attempts at developing a more helpful approach on the part of the personnel, and on possible contributions in the community that derive from our efforts in the hospital. Finally, through a case presentation, it is hoped that we can give you one illustration of how we may effectively develop the mental-health opportunity in the general hospitals.

Only through teamwork can we meet the challenge before us. The nucleus of the team should consist of psychiatric and social-work personnel. It is better, of course, when the team also includes a psychologist and a nurse. If one can call on the clergy and volunteers such as the Gray Ladies that we had in many military hospitals, the team is obviously strengthened. In a general hospital, the mental-hygiene opportunities can be most effectively developed through a psychiatric outpatient clinic with such a staff. The personnel, including the clerical staff and particularly the receptionist, must strive for a group spirit free from interpersonal tensions and conflicts such as one finds in most groups or communities. The goal is to

communicate this group cohesiveness to the patients, so that they may share in this spirit, may derive some strength for themselves from it, and develop a feeling of confidence in the group—that is, in the clinic as such rather than in just an individual of that group. We believe this to be of importance because of the constant shifting of personnel that takes place in all outpatient clinics and that is apt to foster feelings of impersonality and to threaten the good doctor-patient relationship.

In the psychiatric clinic of the general hospital, we see mostly patients who have settled into patterns of emotional maladjustment that are relatively fixed and that, in varying degree, require prolonged psychotherapy and the continued, sustained efforts of the psychiatric team. However, we do see for slight service many individuals whose visits are difficult to include in our statistics. They come for advice regarding school placement, job problems, psychiatric resources in other cities or states, new methods of treatment, the hospital care of relatives, and so on.

Other examples may be found in the work of the admitting psychiatrist or the social worker, who not infrequently must cope with a clinic patient referred as an emergency. He may turn out to be sullen and resentful over some lack of consideration of himself as an individual that he has experienced in another clinic—a situation by no means uncommon in a large and busy hospital. Frequently, such an individual will respond in very satisfactory fashion to nothing more than an opportunity to ventilate his resentment and to the discovery of an environment in which he feels that there is personal interest and attention.

Again, preventive work may consist of nothing more than summarizing in simple language for the patient a long, complicated chart compiled in the course of his bewildered passage through clinic after clinic, with a new doctor in attendance at each and none giving him a definite statement about his symptoms, the findings on a wide variety of tests, or his outlook for recovery. A simple interpretation may work quite a remarkable cure of what appeared to be a very severe and deeply set anxiety state. In all fairness, such examples are far less frequent with the increase of the administrator's efforts at more personalized management of the clinic patient.

The service of the consultant from the psychiatric clinic to the rest of the general hospital differs from the work done in the psychiatric clinic. In the clinics and wards of the general hospital, the consultant has opportunity to do preventive and prophylactic work with incipient emotional disorders. In this type of work, the psychiatrist must be a person with extensive training and with enough experience to be able to act often on no more than intuition in dealing with some very subtle problems. He must also be prepared to deal with a wide variety of frankly psychotic conditions, including schizophrenic reactions, post-partum, senile, and leutic disorders, as well as acute confusional or delirial states. These may require very energetic, resourceful psychiatric intervention, often with the necessity for immediate disposition.

The successful management of these on the general wards contributes greatly to the status of the psychiatrist and of psychiatry in the general hospital. If suitable facilities are available on the general wards, there is the possibility, with selected patients, of demonstrating modern psychiatric treatment methods as part of the program of staff education. Such facilities are usually not available, and if this sort of service cannot be run well, it should not be undertaken. To run it well requires, in addition to special accommodation, competent supervision by experienced, conscientious, able nursing and attendant personnel who cannot usually be held on a stand-by basis for the occasional emergency.

With the growth of interest in the psychosomatic field, we are called upon increasingly for consultation on patients with asthma, migraine, mucous and ulcerative colitis, gastric ulcer, hypertension, skin conditions, cardiac arrhythmia, and coronary-artery disease. The psychosomatic disorders offer particularly good teaching opportunities through supervision of the medical internes and residents in their investigation of the possible emotional factors in such cases.

Besides the problems mentioned above, there are a wide variety of anxieties and defense reactions to be seen on all services. It is impossible to give examples in the space available here. However, there should be a brief comment on the opportunity in pediatrics for the consultant with special skills in work with children, for he can make one of the most im-

portant contributions in this field—not only to the children themselves, but to the parents and their medical advisers. One must emphasize the same old theme of the need for the physician to think of the presenting complaint in terms of the "wholeness" of the individual child. Special efforts must be made to meet the child's great anxiety and inability to understand. The parents require special consideration in this highly charged emotional situation. In pediatrics, the attitude of the personnel on the wards is of particular importance, for the child must endure separation from the parents and enter into an unusually strange, bewildering, and often terrifying situation. The nurse who can be a tolerant, accepting, understanding, and supportive mother-substitute is obviously an urgent need.

An attempt to engender the same attitude of understanding and supportive tolerance in all personnel presents one of the great opportunities for the consultant in the general hospital. Hospital administrators are increasingly aware of this need, and are much more alert to the very real dividends to be derived when patients are given the dignity that is their due as individuals. Efforts are being made to promote more courtesy, patience, and understanding on the part of registrars, attendants, and nurses; to schedule visits so that the patient does not spend long hours waiting on benches; to consider the anxiety and defensiveness that so many patients bring into the hospital setting.

Most physical illnesses are accompanied by varying states and degrees of misinformation, misunderstanding, apprehension, and fear. Recognition of these emotional states in all illness is a development of comprehensive medicine which is again to the fore—for which the psychiatrist deserves some credit, although such recognition has always been important in the art of the good general practitioner and the really keen specialist. In some hospitals, development of a greater understanding and consideration of the patient is going forward through sessions of personnel—usually through didactic lectures, but best carried on through group discussion which utilizes techniques akin to those of group therapy.

The effectiveness of this method was demonstrated in spectacular fashion in a military prison. In group sessions, the guards discussed the aggression and counter-aggression

existent in such a setting. To-day, similar procedures are proving of value in the New Jersey prison system. By any method, one can predict that efforts will be most worth while if they produce a more personalized approach to the patient. This, in turn, brings a greater sense of security to the patient and more rapid establishment of a relationship that facilitates diagnosis and treatment. The psychiatrist on the staff of the general hospital should also work patiently and not too aggressively with the chief of clinic or with the medical director in promoting such attitudes on the administrative level, thus stimulating the establishment of essential modifications.

In addition to attempts to modify attitudes toward the patient, the psychiatric consultant in the general hospital can often convey information to the internes and residents that will promote greater understanding and interest on their part in the total life situations of their patients. One can quite easily demonstrate the importance of the first interview and the need to permit even a most circumstantial patient to give his complaint in his own words and as fully as possible, with particular emphasis on the setting in which the symptoms first occurred. It is not difficult for the young doctor to see that this makes for a more accurate diagnosis than one based on drawing a red line around the particular set of organs about which the patient may complain or on which the physician's special interest may focus. There are a variety of new developments in this direction, both in hospitals and in medical schools, much of the stimulus and effort coming from the internists themselves.

Opportunities that we find in the general hospital for promoting mental health can be carried into the community. We deal frequently, of course, with very lonely and isolated individuals with whom one of our major efforts is directed toward reintroducing them into community life. But, ordinarily, our patient is a member of a family group. Success or failure with the individual may be dependent upon our influence, direct or indirect, on that family group. In any case, the attitude that the patient carries away from the clinic toward his experience is bound to affect other members of his family and possibly others in his community. Even if we are unable to achieve any success in dealing with an emotional problem, the interpretation of the patient's needs given to the

family will have an important effect on their tolerance and helpfulness toward him. It will also allay their own anxieties about themselves as relatives of the patient, and bring about a change in their own attitudes toward mental illness, which they will convey to those in the community who may know of the patient's illness.

If we can do a good job of interpretation, we will have chipped away one small bit of the colossal dread of mental illness which is so great a problem in our efforts to promote better attitudes toward that type of disorder. The effect on the community of a single case may be imperceptible, but on the basis of reports from many families and agencies, follow-up visits from former patients, and particularly cases referred by former patients and their families, we are convinced of the cumulative effect of consistently good efforts.

We have opportunities to reach still another group in the community through certain of our patients. The most effective presentation of this approach will be to give a brief summary of the clinic experience of one patient. This individual was a single man of thirty, who suffered from asthma. It was obvious to his medical advisers that there was a strong emotional factor in his attacks, and he was referred to the psychiatric outpatient department. Throughout the course of his illness, we worked closely with the allergy clinic, maintaining the relationship chiefly through the medical social service and our own psychiatric social workers.

In the psychiatric clinic, most of the preliminary study and definition of the man's basic problem was made by a medical student under the close supervision of an instructor. The man's problem was discussed weekly in a conference of all the medical students who were assigned to the clinic at that time, with one of the senior psychiatrists and the chief social worker as leaders. The interest and enthusiasm of the students were in themselves important factors in this man's progress. His growing confidence and inner security were further bolstered through his other contacts in the clinic, particularly with the social workers.

We shall not attempt any extensive summary of his history. It is sufficient to say that he was the only child of a widowed mother who was living and remarried to a man whom the patient resented. They were dependent on the patient. His

strivings for education had been frustrated by this dependence. The step-father showed little inclination to do more than play the rôle of a Mr. Micawber, waiting for something to turn up, but in the meantime quite ready to accept full support. Two years before admission to the clinic, the patient had fallen ill with a respiratory infection, and an asthamatic tendency quiescent since childhood had been reestablished. He was unemployed and was considered unemployable.

Gradually, as his confidence was restored and his resentments were ventilated, his potentialities for employment became more obvious. We discovered that he had formerly been carried by the city health department as a tuberculosis suspect. This made it possible for us to turn to the New York Tuberculosis and Health Association as a resource in securing retraining for him. But, first, he was sent to the United States Employment Service for aptitude testing and vocational guidance. They made their recommendations, and the Tuberculosis and Health Association advised that we might be able to finance his retraining through the state bureau of rehabilitation. This organization coöperated and he was given an opportunity for training in a field that would not offer unusual stress and unfavorable stimuli toward exacerbating the asthma. Moreover, it was in a field that would not be too highly competitive.

During the retraining period, his family needed assistance, so we turned to a family agency and to the department of public welfare. In spite of fluctuations in his illness, he has reëstablished himself as a self-supporting individual with greater self-sufficiency and lessened resentment. His improved health and the use he made of community resources came through his confidence in the hospital and its clinic personnel, both in allergy and in psychiatry.

At one critical point in this man's progress toward self-sufficiency, we had occasion to call a conference of representatives of the various agencies involved. It was quite an impressive show. A European visitor who attended the conference was amazed that all of these individuals had expended time, money, and effort on the rehabilitation of this one man. We could stress to him the worth-while gains in such an effort without having to resort to any more elaborate explanation

than the demonstration and teaching value. Here assembled were the team of our own psychiatric clinic; workers from medical social service; workers in tuberculosis; workers in rehabilitation; employment counselors; personnel from the department of public welfare; family case-workers; interested foreign visitors; and medical students and internists in training.

The European visitor was warranted in questioning whether we were justified in expending all of this effort on one individual when we were under so much pressure from all sides. It did require much time and effort on the part of our psychiatric social service to bring all of this organization to bear. But we say that we want to convey a wider understanding of mental-health problems and methods. We say that we want to weld the community into a close-knit team in our efforts to achieve better mental health. What better demonstration and teaching for these purposes can one offer than to permit representatives of coöperating agencies to participate in the restoration of an individual whom they might have considered hopelessly neurotic and inaccessible?

The patient-doctor relationship has been threatened by the complexities of modern life, by the impersonality of life in great cities, and by the greater degree of specialization in the medical profession. We believe that it is important in the general hospital to develop sound attitudes on the part of all personnel and an atmosphere that will communicate to all patients a feeling of security, acceptance, and confidence in the hospital and its clinics as such, as well as in individual staff members. We believe that we should be preoccupied with the patient in his totality, a philosophy basic to healing. This can be projected into the community by thoughtful coöperation with others also interested in the health and adjustment to life of our patients. Use of these concepts should go far toward solving the problem of the reëstablishment in clinic medicine of the very positive and constructive relationship that existed between the patient and his personal physician.

MENTAL-HEALTH ASPECTS OF HELPING PEOPLE*

ARTHUR P. NOYES, M.D.
Superintendent, Norristown (Pennsylvania) State Hospital

THE topic suggested by the title of this paper is one to which social workers have probably given more thought than have psychiatrists. It is perhaps desirable, therefore, that it be considered to-day by a group in which these two closely affiliated professions are so largely represented. Particularly in the public-assistance branch of social work, the case-worker has opportunity to observe the effects upon the personality of extending financial help to the individual. If in what follows I seem to be sparing in my references to the social worker and her special knowledge and techniques, it is not because of any doubt as to her skill and the value of her individualized approach to diagnosis and therapy, or with any implication that she does not aim to promote at one and the same time both the welfare of the recipient of aid and that of society.

To confine a discussion of the mental-health aspects of helping people to the narrow limits suggested by the title will be to ignore many related matters which breadth of consideration should include. While some of the subjects that I shall attempt to review do not come within a strict definition of the title, yet they all, I hope, have mental-health implications.

Democracies, with their practical belief in the value of the human individual, are now passing through a period of significant social evolution. This evolution is perhaps moving at a particularly accelerated rate in the matter of concepts of social responsibility. Never before has society recognized to such a degree as it does at present its responsibility for those of its members whose needs, whether in the field of economics or of health, cannot be adequately met through individual effort. The circumstances that render the individual unable to make sufficient provision for his own welfare or that of his

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dependents may be either extrinsic or inherent in his personality.

This extraordinary increase in society's acceptance of responsibility for its members is not a social experiment. Rather, as we have just said, it is a phase or stage in the process of social evolution. During this period of rapid development, many social measures have been enacted into law. During this same period there has also been a remarkable advance in the study of the human personality. It is, therefore, well for us in helping people to pause and consider not merely what we are doing *for* them, but also what we are doing *to* them.

The giving or the receiving of aid in promoting the welfare of the individual introduces the factors of human relationships and of their dynamic influence upon personality functioning. Whatever, from the viewpoint of the psychiatrist, exerts a dynamic influence upon the personality and its functionings has mental-health implications or effects. It naturally follows, then, that, as in most of the problems facing society, there is a mental-health factor in the one that we are discussing to-day. It is quite fitting, therefore, that the psychiatrist inquire into the mental-health aspects of efforts to meet the welfare needs of the individual. Such an inquiry will raise many questions. As you will see, I have no conclusive answers to them. I am sure, however, that you and other students of the social scene will agree that they merit consideration.

The present period of social evolution has been characterized by two developments: first, there has been a change from the attitude that relief should be regarded as a gift to the concept of relief as a right—*i. e.*, as an assistance established by law and for defined, objective reasons. The principles of human rights and human needs have been increasingly recognized as complementary. It should not be forgotten, however, that the obligations between the individual and society are mutual, not unilateral.

The second development is that psychological insights are as much needed in the treatment of economic problems as they are in dealing with emotional difficulties. The first development continues, in some of its applications, to be a matter of controversy. The second, promoted largely by social and psychological sciences, is still not sufficiently recognized by

the legislator and the policy-maker. It is through a development of the concepts of social case-work illuminated by a dynamic psychiatry that the way has been pointed out whereby the psychological can be translated into realistic methods of helping people.

Society has to an increasing degree assumed responsibility for the physical welfare of the individual. The psychologically minded sociologist will argue that the application of this responsibility implies the corollary of an accompanying responsibility for the recipient's psychological well-being. The psychiatrist no longer divides the organism into two unrelated parts—body and mind. Physical welfare and psychological well-being are likewise inseparable. It is highly desirable, therefore, that all those engaged in promoting people's physical welfare should have some understanding of the factors and forces that promote strength and independence of personality, as well as of those that encourage regression and dependence. For this, as well as for other reasons, the student of social work is now given information about the development and structure of the personality and the effect of social and emotional influences upon its integrity. It is highly desirable that not only the dispenser of relief, but also those in higher social-welfare echelons—the legislator, the administrator—should keep pace both with social change and with the increase in understanding of human nature. It is, I am sure, not through lack of good intentions, but through lack of understanding that these higher echelons sometimes evolve ways of helping the individual that fail to strengthen his personality. Perhaps the social worker and the psychiatrist should be more active in showing them that provisions for physical welfare should not be inconsistent with personality welfare, that the help given must be rendered in the light of present-day insights into the human personality. Such insights into personality should be both a constant incentive to social action and a corrective of it.

An important change that has developed simultaneously with the increase in the sense of social responsibility is the realization that helping people should not be in part, or even at all, a matter of sentiment. We like to believe that it is through the insights of the psychiatrist and the psychiatrically trained social worker that there is an increasing effort to

make sure that the methods of helping people are psychologically healthful. There is undoubtedly an increasing emphasis on this objective, yet helping the individual may be accompanied directly or indirectly by unwholesome effects upon his personality. Please do not think for a moment that I wish either to deny our duty to help, or to depreciate the improvement in physical welfare or the stimulation to personality development that should follow for the beneficiary. These are the basic objectives and they are attained to varying degrees. But in our effort to be objective social scientists, we should occasionally take stock of socially beneficial measures and eliminate, if possible, any accompaniments that are indirectly undesirable. What I shall have to say will in part point out potentially harmful effects upon the mental health of the individual helped, in part will refer to constructive effects, and in part will be merely reflections, as collateral and as immaterial as the *obiter dicta* of the judge.

One of the first questions that the psychiatrist asks when a person receives help from, let us assume, a public-welfare agency is, "Will the capacities of this individual for personality growth be undermined or strengthened by this help?" Probably to a large extent the effect will be determined by the situation—whether the help was required because of external forces beyond the control of the person needing help, or whether it was sought largely or entirely because of factors within the person. The answer depends, too, upon whether personality-determining factors made it impossible for the individual to have developed those strengths and maturities of personality which manifest themselves in thrift, stability, and responsibility. If the previous personality pattern was one of self-sufficiency and independence, and if the help was required because of circumstances outside himself, then the individual will almost certainly make productive and constructive use of the help, and personality development will have been even further stimulated. Any future misfortunes will be handled with buoyant resiliency. If, on the other hand, the need for help occurred in a chronically dependent person and largely because of factors within himself, the help, though beyond question necessary, will very likely still further promote regressive, dependent tendencies. It is not at all uncommon to find that the field in which help is sought

is not the fundamental one. The individual who is ignorant of his own personality may be besieged by irrational forces and develop excessive and distorted needs.

In spite of the fact that among those who seek help there are many whose inner potentialities and external resources are limited, yet the case-worker should assume that the applicant for help has personality strengths—perhaps latent or unorganized, or perhaps blocked, confused, or distorted—which with the worker's assistance may be developed until the recipient becomes able to utilize his capacity for growth and change, and thereby becomes competent to meet his problem adequately. The fact that the social worker, even in public assistance, has moved from the mere provision of goods and services and the narrow external aspects of family maintenance and relief to the more psychological areas of family guidance represents a desirable advance toward making better mental health possible.

Instructed as to the nature of social problems and with a knowledge of dynamic psychiatry, the social worker makes a comprehensive diagnosis which includes the individual with his personality assets and liabilities and the family setting with its interpersonal relationships, as well as the economic and employment situation. The worker may find that personality growth has been restricted not only by deprivation, but also by conflicts. Guided by an inclusive knowledge, she should be able to recognize the need and its causative factors. If she can direct the nature of the help and the manner in which it is given, she should be able to minimize the deleterious effects that the immature and inadequate personality may sometimes suffer through being helped.

She will discover that the recipient's way of responding to the problem in which he requires aid is of significance. Does he look upon the problem as a challenge? Have previous adaptive mechanisms been effective and appropriate? What have been the recipient's previous reactions to frustration? Have frustrations increased personality resources or have they caused the individual to become demanding, impatient, aggressive, and hostile, involved in a vicious cycle of fear and hate? What have been his habitual patterns of defense? What and how strong have been previous patterns of dependence or of self-dependence? Does he place responsibility for

his need for assistance outside himself? To what extent has he tended to assume responsibility for himself? Has he shown a narrow absorption in himself? The answer to such questions as these will assist in determining whether or not the recipient will use help in a regressive or in a constructive way. One should, therefore, know not only the economic, but the psychological circumstances under which help is needed.

We have indicated some of the personality assets and liabilities which, in a person who is unable to cope with his own affairs, may largely determine the effect upon him of receiving aid. What are some of these effects? What are to him some of the emotional implications of being given aid? What are some of the other psychological aspects that may be of significance either in giving or in receiving aid? It has already been implied that in some persons the need and its relief may stimulate endeavor, while in others dependence and regression may be promoted. Many a psychiatrist is familiar with the chronic, dependent, and regressive pattern developed in veterans of immature and poorly integrated personality through well-intentioned, but psychologically unsound policies on the part of the federal government. Regression, not growth and strengthening of the personality, was all too often the result.

Many factors will determine whether and to what extent the recipient's initiative will be impaired. Ego functions may be strengthened or weakened. In the former case, the recipient will become an increasingly self-responsible and self-directed person on a reality basis. In the latter case, unconscious forces will doubtless find undesirable expression and the recipient will tend to disregard social reality. While by no means the only dynamic factor that contributes to regression, a feeling of loss of status may act in that way. Humiliation and apprehension as to status may be created, may stimulate defensive reactions or arouse feelings of anxiety which, in turn, may make the recipient more dependent. The social worker will seek to maintain or to restore his self-respect. The recipient should be made to feel that he is respected and of value, that he is not unworthy. Otherwise feelings of distrust and resentment may be stimulated. The fact that the situation predisposes to defensive reactions should be borne in mind.

Mingled with feelings of resentment may be those of insecurity, with resulting fear. Resentment, too, may easily create hatred and aggression, both of which may find overt expression. A resentful frame of mind may prompt a similar attitude on the part of others. Latent prejudices and other products of emotionally determined thinking may be aroused. Unconscious influences and the threat of unresolved tensions may long have been operative in the personality and be of dynamic importance in determining the reactions to the frustrations and the insults to pride that a need for help may have caused.

Illness, poverty, or unemployment will have varying meanings for different individuals, depending on degree of personality development, previous life experiences, and perhaps unconscious factors that may have contributed to the need for help. The recipient will doubtless bring into the situation both rational and irrational attitudes about his needs. His way of responding to his problem, his feelings about it, and the extent to which he will participate in its solution will be decisive factors in his use of help. He may be blocked by fears and inhibitions. Anxiety may be generated in other members of the family. An impairment or loss of sense of security is to be expected, but it should be remembered that there is no genuine security in being dependent on others. Dependency, too, may be a neurotic solution for conflict.

It is now an accepted psychiatric principle that the human personality grows largely through relationships with others. One outgrowth of a psychiatric approach to helping people is the aim of making the occasion one in which personality growth will be promoted. Through sharing the recipient's problem the social worker, in giving assistance, endeavors to create a relationship that will promote personality health. It is through such a relationship that the various resistances of the person who needs help and his deep, obstructive emotional factors may be overcome.

One feature of the increased sense of social responsibility is the improvement in administrative practices in public assistance whereby the recipient of relief is placed less and less in a stigmatized group. It is charged by some that there continues to exist an attitude—largely unconscious—that the conflicts experienced by individuals are due to some fault in

themselves. There has, however, been an increasingly sincere respect for individual personality. Perhaps we should ask ourselves if sometimes we help people because we feel guilty about our own selfish desires or because we are attempting to compensate for meanness in ourselves.

What I have wished to stress in the foregoing is that the giving of help to people is not merely a mechanical process, but one that involves an interplay of emotional forces that may have a far-reaching effect upon the mental health of the recipient. So far as possible it should be a growth-producing experience that promotes emotional and personality maturity. Let us now turn to a somewhat different phase of the subject.

The services that a responsible society must consider providing for those individuals who cannot unaided meet the problems of living are of wide diversity. The need for one service, now the subject of acrimonious discussion, and one that calls for thoughtful and unemotional consideration, arises from the fact that the cost of modern medical care has outstripped the capacity of a large group of citizens to meet it from current earnings or savings. It is because of the many considerations that can be weighed against this single fact that sharp differences of opinion have arisen. The only justification for considering this controversial subject in the present setting is the fact that it has mental-health aspects which have usually been ignored in the acerbic language and temper of debate.

Before discussing some of the mental-health implications of a national health service, I should like to call attention to some features of medical practice that relate to it as a profession rather than to the beneficiaries of a state welfare service. To maintain its integrity, medicine must, I believe, remain a self-governing guild, although within the framework of a contemporary society. There is, in the opinion of many, a tendency for organized medicine to lag somewhat behind the progress of social evolution. For this reason medicine has alienated some who have a sincere and deep interest in its welfare and whose friendship should be prized and cherished. The tendency of medicine to isolation may have contributed to this lag.

During the past fifty years, medicine has been subjected to two major influences: first, the expansion of knowledge and

technical skills in the basic sciences; second, the evolution of the idea of social responsibility. This second influence reflects the social philosophy of the period. As a result there has grown with the years an increasing demand for a wider provision for medical services. Coincident with this the concept has gradually evolved that the responsibilities of medicine to society are paralleled by the responsibilities of the individual physician to his private patient. That medicine, in the perspective of the social evolution of the past hundred years, must finally accept this responsibility, seems certain. The technique, however, by which medicine will assume this obligation remains one of the most important and difficult questions of our time.

I have no solution to propose for this problem. Probably this will be found only with time and experience. Some think the solution should be by a nationalized health service. I cannot believe that this is the answer, and a little later I will discuss some of the undesirable results that psychiatry would suffer thereby. First, however, a few comments. Justice Douglas, of the Supreme Court, recently said, "The foremost problem of society to-day is to cultivate and preserve incentive and independence for the individual and security for the masses of the people." While a nationalized health service would, we must assume, contribute to the security of the masses, is there not danger that it would be at the cost of the incentive and independence of the physician? We know that the state, with its centralized planning and its hampering restrictions, tends to arrest individual, spontaneous creativity. Would there not be danger that such means of meeting welfare needs would frustrate, instead of satisfying, the emotional needs of the physician? It seems almost certain that the morale and integrity of medicine would be impaired if its position became one of contract rather than of status. The physician has been a proud participator in the most humane of labors, and the essential vision and purpose of medicine in the scale of human values are too high to be permitted to suffer degradation. Its traditions should continue inviolate. Were there extensive and intimate governmental supervision of medicine, these traditions would undoubtedly be seriously impaired. Any conditions that leave the physician frustrated will weaken his faith in the ideals of medicine.

Dr. James Halliday, the English psychiatrist, author of *Psychosocial Medicine,* describes the present English general practitioner as follows: "Harassed, pressed for time, writing prescriptions, signing forms and certificates and so on, all he can achieve is the picking out of the more obviously ill organic cases, the appeasement of the nonserious ones, and the reference to a hospital or clinic of the doubtful or obscure ones." It is obvious that under such frustrating conditions the social health of medicine must suffer a corroding deterioration.

It must be admitted that there are large groups of society to whom the resources of modern medicine are not available; also that it is not to the credit of organized medicine that it has been slow in formulating plans for providing them. The high esteem in which medicine has been held will be maintained if, without emotionalism, it presents a positive program consistent with social evolution. All those who are responsible for formulating plans for a medicine that will meet the needs of developing social changes would do well to remember the words of Sir Henry Cohen, President of the British Medical Association: "Ideals often create machinery and machinery without ideals rusts into decay."

After this scarcely pardonable digression let us return to material more relevant to the subject. When the subject of compulsory health insurance is considered by the psychiatrist, his attention naturally focuses upon such aspects as (1) its salutary or deleterious effects upon the mental health of the individual; (2) its social effects; (3) the effect upon psychiatrist-patient relationship; and (4) the effect upon the quality of psychiatric practice.

Broadly speaking, people are characterized either by maturity and independence or by immaturity and dependence. It is safe to assume that the former will, through their own initiative, seek a security for their future. Whatever the motive or drive that impels such persons to provide for their future and that of their dependents, a compulsory insurance would not greatly impair their initiative or decrease their effort to prepare for their future. On the contrary, such insurance might stimulate them and exert a constructive influence. While the immediate object of a compulsory health insurance would be to lessen economic anxieties incident to

disability for gainful employment, yet in the case of the immature, inadequate, dependent person, deficient in sense of values and responsibility, a compulsory insurance, far from being a stimulus, might further promote improvidence and irresponsibility, and accelerate a tendency to dependence upon the state. Some believe that this increasing dependence during recent years has already insidiously undermined the personality stamina of large segments of society. Such trends are regressive. The state becomes the parent dependence upon whom continues.

In addition to the degradation of personality functioning and of social maturity that might follow the adoption of compulsory health insurance, the state would presumably be called upon to assume the burden of care for a group that otherwise would not become public charges. There are many persons of poor mental health—inadequate individuals, psychopaths, mild psychotics—who, stimulated and persuaded by their families, are now fully or largely self-sustaining. With health insurance available, the families of such persons would be less inclined to assume responsibility for them—and they would either become inmates of public institutions or be granted disability insurance. The community would contain more unemployed individuals, persons who might otherwise fill their days with some occupation—perhaps menial, but nevertheless useful. In such unemployed persons, also, there may be a tendency to the development of asocial trends.

A group of persons possessing much in common with the one just mentioned is characterized by a chronic psychological dependence arising out of some socio-psychiatric nexus which results in frequent or chronic unemployment or even unemployability. Could some plan be devised that would serve in such persons as an indirect stimulus to initiative toward self-maintenance and the provision of care for their own health needs? It is doubtful if any contemplated compulsory health insurance would have such an effect.

One feels that the person who can store up security for his future has a quality that should be encouraged, not inhibited by a compulsory process. Since in many instances this quality is probably motivated by deeply seated psychological forces, we doubt if it would in all cases be impaired by external compulsion, yet one asks if there is no alternative but to subject

all persons to compulsion in the interests of those who cannot plan ahead. There is no obvious answer to this question. It is doubtless true that improvidence in a given person is largely determined by complex socio-cultural-psychiatric factors peculiar to that individual. Governments, however, in their commendable effort to promote the individual's security and prevent or relieve anxieties should avoid policies that foster a regressive dependence and inhibit self-reliance and personality growth and initiative. In the effort to meet certain basic psychological needs, care must be exercised not to interfere with a wholesome personality functioning.

It seems certain that the patient-physician relationship would, through the mere existence of compulsory health insurance, suffer more significant harm in psychiatry than in any other branch of medicine. For the relief of emotional pathology, this relationship must be highly personal. It is hardly possible that, with the intervention of the state—even though it were only in a fiscal rôle—this relationship would not be unimpaired in therapeutic value. The establishment of a desirable transference would be less easy. The patient would be less desirous of the approval of his physician. Would the patient be as ready to let down his self-justifying defenses and see himself and his emotional problems in as realistic a perspective in what would seem to be a less personal setting? Would the patient be less sensible to higher motivations of accomplishment, and the therapist's efforts meet with resistance? Would the psychiatrist become a real therapeutic agent or a judge who can be the means of a desired release from responsibility? The patient might no longer be a person who pays a therapist in order to become self-supporting, but one who sees a paid agent who will give him a living.

To profit from psychotherapy, the patient must recognize that deep-seated anxieties are giving him distress and must have an active and genuine desire for relief. With health insurance, it is doubtful if the patient-physician relationship would be as highly personal and, therefore, as therapeutic as in the patient-private psychiatrist relationship. The relationship of confidence between patient and psychiatrist would probably be impaired. On its highest plane this confidence can scarcely exist except in private practice, with the patient free to seek counsel from a physician chosen by himself.

There are many other unanswered questions as to how compulsory insurance would affect the significant patient-physician relationship.

It seems quite possible that compulsory insurance would lead to a deterioration in the quality of psychiatric practice. Because of the increased demand for psychiatric services and because of an almost certain increase in difficulty in maintaining a desirable standard of living, the psychiatrist would feel compelled to accept more patients than he could conscientiously treat. By his taking on even a few additional patients, all may suffer through neglect. Inevitably the psychiatrist would derive less professional satisfaction from his work if he felt that the quality of his services had deteriorated and that his failures had become more numerous. Any impairment of professional self-respect or morale would have an insidiously deleterious effect upon the physician. Regrettable as this would be in any branch of medicine, probably in no other would the quality of the physician's services be so subtly impaired.

We have attempted to present some of the aspects of helping people as they are related to mental health. Since a developing social responsibility includes the obligation of helping persons in problems of health, we have also touched upon the controversial question of a nationalized health insurance, with special reference to its application to the psychiatrist and his patient.

Helping people has many psychological ramifications. The effect may be to promote a more personally satisfying and socially useful life. Again, if the help is not given in the light of present-day insights into personality, the effects may be to encourage regression.

VOCATIONAL SERVICES AS AN ADJUNCT TO PSYCHOTHERAPY*

MARY F. BOZEMAN
The National Association for Mental Health

ALL of us here to-day have probably found proof enough in our own experience of the importance of work as a means of self-expression, a means of satisfying our need of being important to ourselves and to other people, as well as —not always incidentally—a means of making a living. Each of us has surely at times resisted the morning alarm, dreamed of a legacy from an unknown wealthy uncle, or believed sincerely that we were perfectly suited for a life of ease and luxury. Yet in spite of our dreams, we probably all believe more or less firmly that, whether or not a person has to work for money, the American heritage and tradition of occupation as an inherent factor in the dignity and health of people is a good, a sound, a workable concept. It is, therefore, hardly surprising that the lack of ability and capacity to work, to work well, and to work with satisfaction is to us a significant, although not the sole, symptom of something wrong with our own or with other people's emotional and social adjustment.

Obviously the ability to attain vocational happiness does not exist in a vacuum. It is influenced by the interwoven pattern of family, community, and religious dynamics, by personality patterns established in childhood in efforts to meet the conflicts and problems of life, and by the social and economic conditions of the world and the society in which we live. But as all parts of our lives influence our working ability and satisfactions, so do our working abilities and satisfactions influence all other parts of our lives.

How important it is, then, for each person who has an emotional or a mental illness that has impaired his capacity to work to be helped to regain that capacity. Vocational adjustment for many patients under psychiatric treatment becomes

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not only a partial goal in treatment, but also a means through which treatment may be considerably implemented.

Ever since the first World War, the vocational rehabilitation of physically handicapped people has been accepted as a nation-wide public responsibility, to be carried out through the Federal Office of Vocational Rehabilitation and public vocational-rehabilitation bureaus in each state. It was not until seven years ago, however, that the federal law on vocational rehabilitation was expanded to enable the states to give vocational service to those people whose capacity to work, and to work with satisfaction, was disturbed by emotional or mental illnesses. This is not to say that nothing had been done prior to this time. State hospitals for the mentally ill had long attempted industrial placement and vocational activity as a part of treatment. Social agencies, schools, and vocational agencies throughout the country could not have avoided, even if they had wanted to, at least the occasional necessity of giving vocational service to persons whose vocational problems were largely due to emotional factors.

However, in 1943—as now—our experience with vocational service as a part of treatment for emotionally ill people was too limited to permit the fullest and most meaningful use of the expanded resources.

From 1947 to 1949, Dr. Thomas A. C. Rennie, Dr. Temple Burling, and Dr. Luther Woodward conducted a study, under the auspices of The National Committee for Mental Hygiene and financed by the Commonwealth Fund, of vocational services for post-psychotic patients. The purpose of the study was to determine the extent of the need for vocational services and the feasibility of that service's being given by the state divisions of vocational rehabilitation. The study has recently been published by the Commonwealth Fund under the title *Vocational Rehabilitation of Psychiatric Patients.* I shall not, therefore, review the findings in detail, but will simply note that it was discovered that a large proportion of patients whose emotional illness had occurred in the teens or early twenties needed vocational service. Patients who had not completed their education or chosen vocational training, who had had limited work experience, who had never found work that interested them, or who had not attained marketable skills, needed counseling service, training resources, or help in

finding jobs to increase their chances of maintaining the gains made under mental-hospital treatment.

When that study was completed, The National Committee for Mental Hygiene, now a part of the National Association for Mental Health, realized that the same kind of information was needed about the patients of mental-hygiene clinics. It was known that some clinics used vocational agencies and that vocational agencies sometimes referred clients to clinics, but we could find no organized information to indicate what proportion of clinic patients presented vocational problems or which of these patients could be helped with a combination of psychotherapy and vocational service. With a grant from the New York State Department of Mental Hygiene, and under the direction of Dr. Rennie, we undertook to find out something about this.

For the study we selected nearly 450 cases from five New York City clinics and one clinic in a smaller community in Michigan. We wanted inclusion of a smaller community clinic in order to broaden the applicability of our findings, and we chose Michigan for this because of the interest and help that vocational-rehabilitation facilities and psychiatric staff in that state had given in the previous study.

We excluded from our group of patients those who had been hospitalized for psychoses because we felt that this part of the field had been adequately covered by the previous study. We excluded also patients for whom clinic service consisted only of determination of the need for hospitalization, because we were most interested in treatment and vocational service as they operated together in the community. We also excluded housewives because we felt that they presented completely different vocational problems and needs which we could not explore adequately in the time permitted for our study.

Early in the project we realized that it was not sound or feasible to limit our view of vocational service to the operation of the divisions of vocational rehabilitation. In New York and in Michigan, the official rehabilitation agency was an important source of service, but by no means the only one. In New York City over a dozen other sources of service, including schools, colleges, and clinic social-service staffs, were represented. It seems clear to us that although there are special problems and perhaps special principals involved

in giving vocational service conjointly with psychotherapy, no agency with a vocational-service function can logically limit that service to the emotionally healthy. If not by plan, at least by chance, every agency and institution has the opportunity and the responsibility to serve people with emotional problems, not necessarily because those people have emotional problems, but because they are members of the group that the agency is designated to serve.

There are, of course, a number of possible breakdowns of the material in this project as one seeks conclusions—breakdowns according to diagnostic groups, educational groups, length of clinic treatment, and so on. To-day we would like to look at it with you from the point of view of age groups.

There was some difference, according to age, in the proportions of patients who presented vocational problems. Generally, patients between the ages of thirty and fifty-five presented fewer vocational problems than did younger or older patients. But probably more significant was the fact that patients in different age groups presented different kinds of problem. Again generally speaking, patients between the ages of thirty and forty-five usually had marketable job skills, vocational direction, and resources for finding jobs for themselves. Their vocational problems were largely in the areas of personal relationships on jobs, and the inability to apply their work capacities because of their emotional problems. For the middle-age groups, then, psychotherapy alone was more frequently effective in aiding toward the resolution of expressed vocational problems than it was for people older or younger.

We are not suggesting here that case-finding for vocational service, or for any other kind of service, can be done on a statistical basis of how many instances were found in some category or other in some study or other. Any service must always be initiated and conducted according to the unique needs of the individual person, but both clinic and vocational-service personnel are helped in giving service by being aware of some of the probable differences in the needs of people in different groups.

In addition to special needs as indicated by age, patients who had physical handicaps in addition to emotional problems and recent European immigrants frequently presented special vocational needs that required vocational service in addition

to psychotherapy. But to-day we want to talk of people according to their years—of the young and of the aging.

We shall mention the aging only briefly, since they are discussed elsewhere on this program. For almost half of the men and more than half of the women in our group who were over forty-five (and we use this age because, from the point of view of employment, this seems to be more and more the starting point of trouble) employment had either been abandoned or had never been considered feasible as a partial goal in therapy. Vocational rehabilitation had been attempted for a few, but for over three-fourths of the patients over the age of forty-five who had vocational problems, no significant improvement of the vocational situation had resulted from any service given. Acute emotional problems, the increase of physical illness and disability, and labor-market resistance to the employment of older workers made the label of chronic unemployability an easy one to apply. But added to this combination of factors was the usual long duration of physical and emotional symptoms before clinic treatment had been sought and the lack of a community plan for handling each patient's problems as a unit. A variety of agencies primarily interested in serving the young or families were largely unsuccessful in their efforts to help the aging.

The vocational problems were great, but they are only a segment of the difficulties with which these patients were confronted. Employment would hardly be feasible for the sixty-three-year-old paranoid, schizophrenic man who works at least eight hours every day cutting uninspired, unmarketable lithographs of Bach. Without lithographs and without psychotherapy, the patient would be in a mental hospital. Our society must be large enough and strong enough to support some uninspired art. But we must also be large enough and strong enough to provide, for people who do not have such natural outlets, a few hours of work, sheltered, medically supervised work, and cautious, delicately timed encouragement toward activity suited to their emotional and physical capacity without threat to their economic security. We must be large enough and strong enough to weigh the scales against lonely, unproductive lives in which psychotherapy is frankly no more than Scotch tape.

And now of the young—the mental-hygiene-clinic patients under thirty years old. There were 125 people under thirty in our group of cases—about three-fifths of them men and two-fifths women. Of the total group, with only minor differences between men and women, about one-third were students, one-third were employed, and one-third were unemployed at the time of seeking clinic treatment. There is, however, an interesting difference between the men and the women. Nearly all of the women over twenty knew fairly well what their vocational direction was, while only a minority of the men under thirty had found direction. Why this is so can only be guessed at, but a partial reason, perhaps, is the fact that the women generally saw fewer vocational choices than the men. Clerical and factory work were the principal kinds of work done. It is also possible, of course, that marriage is still the desired vocational goal for the majority of women, and the choice of an intermediate occupation is not a matter of as grave concern for them as it is for men. Question can be raised, however, as to what this self-imposed or society-imposed limitation of vocational fields meant in terms of emotional satisfactions in work.

Even with vocational direction, about three-quarters of the women had problems in relation to work. Those who had had no work experience had fears and insecurities about seeking jobs and were considerably aided by a reassuring relationship with some one who knew the labor market and could give guidance about ways of seeking job openings and approaching employers.

Many of those who had had work experience frequently had left jobs or had been fired, had had anxiety and been tense at work, had been unable to concentrate or had had difficulty in personal relations. Although for only a couple of women could emotional disturbance be directly related to the kind of work done, and although emotional illness always has its beginnings in childhood experiences, we may well wonder if some of these women might not have been able to find greater defense against emotional disturbance if their early choice of vocation had not followed such a stereotyped pattern.

The picture for men under thirty was considerably different, in as much as their problems, including job changes and personal relationships, were frequently also related to the choice of a vocation. Two-thirds of the men between twenty and thirty still had no settled idea as to what they wanted to do with their lives vocationally.

Approximately 90 per cent of the men under thirty presented problems of educational or vocational adjustment. Nearly a third of these had received or were receiving service in addition to psychotherapy in relation to their vocational problem. Interestingly enough, the vocational service given was apparently more effective in helping the patients who already had a pretty good idea of the kind of vocation they wanted than for those who were confused about their direction. Help in finding jobs, confirmation of the fact of ability in line of interest, information about the requirements of a specific field, and help in obtaining necessary training produced apparently better results than the efforts of vocational-service personnel to assist in clarifying confusions.

It must be remembered, of course, that these were young men with emotional problems, some with severe emotional problems which were usually a large factor in their inability to decide on a vocation. But we might well give a thought to what our changing social concept of the timing of vocational choice has had on young adults for whom decision at best is difficult. Our standards of more and more education for specific vocations and the ever-widening field of choice tend to delay, particularly in the middle and upper social classes, the material, pressing reality question of how to make a living. It would require a much more profound study than we have been engaged in here to show what influence such social acceptance of the delay of vocational choice and vocational activity has on the boy in his late teens and early twenties who also has acute emotional problems. Is the shy dreamer who is encouraged to search exhaustively for the right job, the one profession, the ideal vocation, thereby protected as he must be protected, until he is more ready to face the world, or is the very protection an injustice to him in that it prevents him from keeping and building on his capacities for relating to the realities of the world? The answer, cannot, of course, be a general one, but it is one that must be sought in

psychiatric consultation and evaluation in individual situations by the variety of agencies and institutions that have an opportunity of contact with adolescents and young adults.

This and other emotional vocational problems are best met when psychiatric services and educational and vocational services are so closely related that they have unquestionably common goals. A high school and a clinic together helped a young schizophrenic boy to overcome his inclination to escape reality in endless academic training by immediately utilizing his artistic talents in a department-store job. Although he might have had potentialities for higher art, the school counselor's knowledge of the pressures and competition in the field, and the psychiatrist's knowledge of the boy's limited capacity to tolerate pressure and competition, combined to help him achieve emotional security and vocational satisfaction.

The same high caliber of coöperative work between a clinic psychiatrist and a vocational counselor helped another anxious, insecure student to follow a course of higher education for a scientific field after evaluation of the suitability of his choice in view of his abilities, the practicality of his choice in view of potential employment opportunities, his emotional need for professional status, and his capacity to delay vocational achievement without becoming divorced from reality.

The task of schools and of agencies that serve students and young adults in the matter of vocational direction is not an easy one. Nor is the clinic task in serving these patients usually easy. A psychiatrist cannot know enough of the field of pure math, of stock and shipping, of building construction, or of retail sales, to be able to judge their characteristic requirements and availability in relationship to the emotional needs of his patient. Nor can school and vocational personnel fully evaluate the degree to which a student's or a client's avoidance of people, expressed desire to serve people, love of philosophical abstractions, or insistence upon manual labor is an expression of the turmoils of growing up or a symptom of deeper psychoneurotic problems.

We have seen gratifying successes in coöperative work between clinic psychiatrists and vocational personnel as they combined their skills and knowledge in service to individuals. But we have not seen enough of it. The clinic patient who spent three years in a college course which he chose in an

effort to compete with his brother, with whom he could never successfully compete without anxiety, undoubtedly has graver emotional problems than he had three years ago. The patient who sought vocational counseling three different times and received training in three different fields could surely have been earlier identified as an individual whose vocational indecisions and desire for change were a result of emotional problems rather than of a normal desire to find the "right job."

In conclusion, we may say that our world is a complicated one and not without pressure and conflict even for those rare, untroubled souls who manage to find their own way. For all young adults, whether or not their childhood years have left a fertile soil for psychoneurosis or psychosis, help should be available when they need it to discover the degree of vocational pressure and challenge and the degree of postponement of goals that they can tolerate, and to evaluate their intellectual and vocational potentials in relation to that level of toleration. For those who have special emotional problems, these services, psychiatric and vocational, operating in unfailing relationship to each other and to the individual's unique needs, are essential if we are to save our greatest national and world wealth—the individual's capacity to be happy, to be productive, and to carry his own weight of social responsibility.

CONSTRUCTIVE PROGRAMS FOR THE MENTAL HEALTH OF THE ELDERLY*

FREDERIC D. ZEMAN, M.D.
Chief of Medical Service, Home for Aged and Infirm Hebrews, New York City

WHEN I first became interested in the problems of the aging some twenty-five years ago, old age was something that happened to the other fellow. But as the years have raced by, the implications have become increasingly personal. Soon I shall be in the embarrassing position of being forced to practice my own preachments.

As evidence of my present youthful attitudes, I shall proceed at once to violate long-established tradition by failing to quote Horace's famous description of the foibles of old men, since Latin quotations are certainly out of date. Furthermore, I shall resolutely restrain my impulse to preface my remarks with an exhaustive historical review of the mental hygiene of old age, because, to some of my colleagues, an interest in medical history is considered a sure sign of precocious aging.

My assignment here is to discuss constructive programs for the mental health of the elderly. Our generation may well take credit for attempting to meet the problems of old age in an objective, realistic manner, devoid of condescension or contempt and free from an unreasoning emotionalism. We have been forced into action by an astounding increase, not in the maximum duration of life, but rather in the average length of life, caused by the addition in the past fifty years of sixteen years to the life of every man and nearly eighteen years to that of every woman. Many more men and women are living to the ages of sixty, seventy, and eighty, but so far there are no more centenarians than in the past.

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Our discussion will be facilitated if I pause at this point to define terms. In 1909, the late Dr. Ignatz Nascher, of New York City, coined the word "geriatrics," to denote a branch of medicine devoted to the diagnosis and treatment of disease in the aged. Although this word is rapidly approaching a respectable middle age, it is only within the last few years that it has come into general use, and there are still many who are unfamiliar with its meaning. It does not imply that the disorders that occur in older people should constitute a medical specialty, since these conditions are an essential part of internal medicine. It is to be looked upon as a convenient word that groups together a variety of related concepts.

Another new term is "gerontology." This means literally the science of old age, or, more broadly, the scientific study of the aging process in all living matter. Where geriatrics is limited to human beings, the student of gerontology also utilizes rats, mice, dogs, birds, elephants, or amœbas as they suit his purpose. In another sense, geriatrics works at the bedside, gerontology in the research laboratory.

Once defined, these words are useful additions to our everyday language. This is not true of the commonly used phrase, "degenerative diseases," long known to be a cloak for ignorance and of late proven so by the implication of arteriosclerosis, in part at least, as a nutritional disorder, and the discovery by Kendall, Hench, and their coworkers that arthritis is related to an adrenal-gland deficiency. This term should be dropped by all who are interested in using language to convey precise meanings.

My chief dislike in matters of terminology are the words, "senile" and "senility." Literally, they merely mean "old" and "old age," but they have acquired the connotation of mental disorder associated with age. You will even hear people talk about "a senile old man." One also encounters the adjective used as a noun, as in "seniles," meaning mentally deteriorated old people of all kinds, degrees, and varieties, although often the implication is of a vague, border-line state. Their loose and uncertain meanings necessitate that these words be dropped entirely in favor of specific, accurate designations that admit of no misunderstandings.

In the last quarter of a century, a steadily growing understanding of the mind in old age has led to an extension of the mental-hygiene movement to the later years of life. We have ceased to blame the old for their peculiarities. The effort has been made to explain why old men grumble and complain, why they seem to have lost interest in the world, and why they lose confidence in themselves. While completely satisfying answers to all these questions are not available, enough insight has been gained to make possible programs for bringing more happiness and greater satisfaction into the lives of the aged and reducing the frustrations from which so many of them suffer. The provision of economic security alone is not enough to accomplish these purposes, since the well-to-do must face reality as well as the indigent.

I cannot stress too strongly that the mental abnormalities seen in the aged are not necessarily the result of age. Many of the difficulties date back to personal maladjustments of long duration. It is clear, therefore, that contributions to the mental health of children and young adults are also contributions to the mental hygiene of old age, conferring greater personal insight and at the same time better understanding of older members of the family group, as well as laying a sound foundation for the future. Immature, compulsive, narcissistic, and psychopathic personalities often attain old age without the improvement, or "mellowing," that long years are popularly supposed to bring. Of all the adjustments that life demands, the realization of old age and the adaptation to it is the stiffest test of mental stability. It is not surprising that those who have previously had difficulty in meeting reality will have even greater trouble at this trying period.

As regards the actual psychoses of this period of life, let me point out that refined and painstaking diagnosis is required to separate the psychoses caused by brain-cell and blood-vessel deterioration from the many conditions that may simulate them. More and more we are beginning to realize that the clinical pictures due to organic brain changes may be precipitated by extrinsic social influences. We know that patients with severe brain damage may behave normally and that others with minimal brain changes may be frankly psychotic.

Mental disorders originating in youth may continue into old age and if the earlier history is not known, may cause confusion. Dr. Manfred Guttmacher, of Baltimore, has written a fascinating book, *America's Last King,*[1] a psychiatric study of King George III, who, as we all learned at school, was insane. What we did not learn was that he suffered from manic-depressive psychosis. The first attack was at the age of twenty-six years. The fifth and fatal attack occurred at the age of eighty-four years, and is in no way to be thought of as a disease of old age.

Mental disturbances in the old may be due to nutritional deficiencies, to drug intoxications, to illnesses and cardiac failure, as well as to overwhelming misfortune, the so-called "reactive depressions." Some of these depressed states in the old are amenable to treatment by shock therapy. Vitamin administration and proper diet will clear up the deficiency states, and the withholding of drugs will likewise have a curative effect. Psychoses after surgical operations are not rare among the old and are to be ascribed to complex causative factors.

The important thing to remember is that the outlook is good for complete recovery under appropriate treatment and good nursing care. My optimism about the cases that can be helped must not obscure the tragic picture presented by the organic psychoses of old age caused by the actual destruction of brain tissue. The increase in these cases has gone hand in hand with the increase of the aged in the general population, and their care in state mental hospitals presents one of our gravest problems.

Certain facts are basic in any consideration of mental health in the elderly. Old age is a significant period of life and must be consciously faced and prepared for, exactly as in childhood and youth we prepare for the period of maximum activity. "A healthy mind in a healthy body" is just as important a goal of the later years as of the younger. A large part of the mental insecurity of old age is based on physical disorders and handicaps. Even more than in youth, the brain is affected by the disordered function of the body as a whole.

[1] New York: Charles Scribner's Sons, 1941.

Age is not a matter of birthdays, but of functional capacity. People grow old at different rates. Some are old at fifty, others young at seventy years. This tyranny of birthdays is so firmly entrenched, both in our laws and in our mores, that it must be fought against at every opportunity. Compulsory-retirement ages are but one aspect of this problem. I have often told the story of the elderly man who once consulted me, giving his age as eighty years and his occupation as salesman in a department store. When I asked him how he managed to hold his job at his age, he replied, "Down at the store they think I am only fifty-eight."

There is a growing conviction among physicians that many mental breakdowns in old age are preventable, that lack of understanding on the part of associates and relatives is more important than actual disease, and that loneliness, rejection, and withdrawal may be successfully combated. The exploitation of old people by political demagogues is familiar to you all and needs no further elaboration than the comment that a by-product of a successful mental-health program will be prevention of the formation of these political-pressure groups by discontented old people and will eliminate their insistence on special benefits for themselves at the expense of other important social-welfare programs, such as we have recently seen in California.

The problems that a mental-hygiene program seeks to solve are these: those arising from old age itself and its associated diseases, those arising from the state of dependency, and those arising from the make-up of present-day society. While aging brings with it a gradual slowing up of sensory processes, and of memory, attention, and learning ability, these changes come on slowly and at different speeds in different individuals. They must be thought of as partial rather than total losses. We are frequently asked, "Can an old dog learn new tricks?" To this we can answer with assurance, "He certainly can, if he wants to!" Old people often show an increasing lack of adaptability to change. The minor annoyances of life, changes of scene, and forced alteration of habits are not easily accepted, and the old person develops anxieties and depressions, becomes sad and morose, and may actually repel all efforts at assistance.

The fact of dependency is a bitter reality for the aged to grasp. From childhood onward, we are taught to provide for our old age, and savings are accumulated with the idea in mind that one day earning power will be gone. But because of the unpredictable nature of financial depressions, savings go by the board, and many a thrifty couple, through no fault of their own, find themselves in their sixties dependent either on their children or on the state. Cruel disillusionment is seen commonly in individuals admitted to homes for the aged, which, no matter how homelike, friendly, and kind they may be, nevertheless represent the dreaded poorhouse "over the hill." In the midst even of devoted families, tensions arise, for on every side are silent reminders that the aged parent no longer contributes to the home and that his upkeep is costly. Under present city housing conditions, he cannot have a room to himself and thus sacrifices the precious boon of privacy.

The speeding up of industrial processes has tended to put the emphasis on youth and to make it impossible for older people to gain employment. Up to the present we have failed to make large-scale studies of the functional capacities and skill of older men and women in order that they may be kept at work as long as possible. The war years brought many elderly men out of retirement, back to jobs and to the real happiness that comes of taking part in the work of the world. In modern institutions for the aged, the residents not only enjoy the benefits of occupational therapy, but they also actually help in the activities of the organization in the kitchen, the laundry, the sickrooms, and the garden. The physician in city practice is aware of how much happier the old women are than their mates. The old men have nothing to do, while their wives busy themselves with cooking, "doing up preserves," housekeeping, and the care of young children.

For more complete and accurate studies of the employment problems of old age, I refer you to the publications of the Bureau of Labor Statistics of the United States Department of Labor, whose chief, Mr. Ewan Clague, has given particular attention to these problems.[1] Other valuable material is available in the publications of the Joint Legislative Com-

[1] See *Employment Problems of Older Workers*, by E. Clague. Washington, D. C.: Government Printing Office, 1950.

mittee on Problems of Aging of New York State, headed by Senator Thomas Desmond.[1]

With this as an introduction, I shall proceed without further discursiveness to outline certain programs whereby mental health may be promoted and preserved in older individuals. I shall discuss them under three headings: a basic program of professional education; a program of prevention or anticipation aimed at the middle years; and, finally, an active program for the old themselves.

I have called the program of professional education basic because physicians, professional nurses, and social workers must learn about old age in order to educate old people and their families as well as lay leaders in community-welfare work. The medical man must familiarize himself with the medical and social literature on the subject and embrace every opportunity to attend lectures on geriatric topics by the recognized leaders in the field. For the past five years, I have given a course in geriatrics for graduate physicians at the Mount Sinai Hospital and the Home for Aged and Infirm Hebrews, under the auspices of the College of Physicians and Surgeons of Columbia University. I am glad to report that each year seems to show increasing interest. The Medical Society of the State of New York, through its committee on public health and education, is coöperating with the New York State Health Department in offering a group of lectures on various geriatric topics to the county medical societies of the state. The physician also needs to know the social aspects of old age, should be acquainted with the resources of the community, and should coöperate in stimulating groups to provide new facilities. He must ally himself with clergymen and lay leaders of public opinion to assist in the enlightenment of the general public.

Nursing educators are well aware of the need to teach professional nurses the special requirements of the aged. For the past four years, the Home for Aged and Infirm Hebrews has enjoyed an affiliation with the Department of Nursing Education, Teachers College, Columbia University. Each year a group of over thirty graduate nurses spends two

[1] See *Never Too Old*, by Thomas Desmond. Legislative Document No. 32, 1949. Albany: New York State Joint Legislative Committee on Problems of Aging, 1949.

weeks at the institution studying our methods and particularly our occupational-therapy department. Nurses soon find that nursing the old is rewarding work, since kindness frequently surprises the old patient who is accustomed to being pushed around. Miss Marsh, author of an excellent book on nursing the chronic sick, has emphasized a neglected phase of the nurse's work,[1] in speaking of the chronically ill and the mentally ill: "It is a lonely existence at best, and must be brightened by cheerful companions and a staff with a sense of humor."

Recently, I am happy to report, the first book on geriatric nursing has been published, written in most capable fashion by Miss Kathleen Newton, of New York Hospital.[2] I can recommend it highly.

Social workers must understand not only the basic principles involved in the medical and nursing care of the aged, but, in addition, must be familiar with the problems of dependency, of family relations, of housing and leisure-time activities that confront them daily in their contacts with clients. They must have training in psychiatric work and counseling. They must know community resources and be personally familiar with them. They must have a thorough grasp of federal social-security legislation and the rights of the aged under the law.

The concerted expert efforts of this group will inspire the family and the patient with confidence to follow guidance. An example must be set to the patient of sympathy and understanding tempered with firmness and free from maudlin emotion. The family must be taught that the old man or woman is an individual who can be helped to happiness by intelligent understanding, a human being with certain likes and dislikes, a once potent member of the social group, who cherishes privacy and independence, who is most satisfied when helping ever so little toward the family welfare, and who still wants to be respected and, as always, needs affection.

The program of prevention or anticipation aimed at the middle years is founded on the idea that old age must be prepared for and planned for. It is particularly important

[1] *Nursing Care in Chronic Diseases*, by F. L. Marsh. Philadelphia: J. B. Lippincott Company, 1946.

[2] *Geriatric Nursing*. St. Louis: C. V. Mosby Company, 1950.

for individuals who know that at a certain specific birthday they will be retired. The pre-retirement counseling plan of the Standard Oil Company of New Jersey is a splendid example of the work in this area by a great corporation. We can confidently expect that this example will be followed by others.

The large group of activities generally lumped together under the title, adult education, has the largest part to play in this program. For a splendid survey of this field, I refer you to Homer Kemper's *Education for a Long and Useful Life.*[1] Here we find stated the basic principles on which educational activities may be based, the account of active agencies and programs, and detailed special programs for the older years, with worth-while comments on community planning. Two quotations will be helpful from a listing of desirable attitudes: "Old age should normally be as happy a period in life as any other. Old age can be a golden age." "Adults should continue to adjust during the middle and older years as their changing biological, social, and vocational environments demand. People should continue to learn through life."

In addition to teaching the middle-aged how to live and to grow intellectually, this is a period for the cultivation of new interests, handicrafts, and hobbies, preferably activities for indoors and outdoors, for summer and winter. These need not have any relationship to previous skills or occupations. Some of our best woodworkers at the home are elderly men who previously had no familiarity with the use of tools.

While we are on the topic of education for the middle years, I must remind you of the necessity for teaching these people the facts about sex and what they may expect in the years to come. Too long have we allowed both men and women to think that normal sex life terminates abruptly somewhere between fifty and sixty years. Actually, it continues long beyond, depending largely on the health of the individuals concerned. Long after the physical manifestations have receded into the background, preoccupation with sex continues to play an important rôle in our thinking. Further, let us never forget that to true love there is no limit whatever, either of age or time or bodily infirmity.

[1] Bulletin, 1950, No. 6, Office of Education, Federal Security Agency. Washington, D. C.: Government Printing Office, 1950.

One of the most exciting new ideas in the field of adult education has been the organization, by Dr. Alvin Johnson, formerly Director of the New School for Social Research, of his faculty of retired professors. This group, although out of active work by university statute, is still eager to serve, and it is Dr. Johnson's intention to see to it that its special abilities are well utilized.

Whether bibliotherapy or the use of books in treatment belongs here or in the next group, is hard to decide. It is important to realize that we can all learn about old age from literary works and that the aging may do likewise. Among the older works, one recalls Cicero's *De Senectute,* Cornaro's *Sober Life,* Shakespeare's plays, Montaigne's essays, Bacon's essays, the writings of Oliver Wendell Holmes, and the poems of Longfellow and Tennyson. The moderns, too, are increasingly concerned with the problems of old age. We have Hilton's *Good-by, Mr. Chips,* Sackville West's *All Passion Spent,* Huxley's *After Many a Summer,* and many more. Of particular significance to us to-day is the *Plum Tree* of Mary Ellen Chase, a sensitive study of two great-hearted nurses and the psychotic ladies in their care.

In discussing the active or aggressive program for the mental health of the aged themselves, it is, of course, obvious that the professional worker, educated as outlined above, will be indispensable, even in working with people who come into advanced age well prepared, because not everything can be anticipated and the unexpected may be expected. We shall divide these programs into medical, social, and religious groups.

Among the medical agencies that have a great stake in the physical and mental health of the aged are the general hospital, the chronic-disease hospital, the tuberculosis hospital, the hospital for mental disease, and the home for the aged. Better coördination of effort must be achieved between these institutions. The general hospital often admits aged patients reluctantly because they stay too long. Patients with transitory psychic disturbances are apt to be transferred too quickly from the general to the mental hospital. Even in the chronic-disease hospital aged individuals occupy beds long after the need has gone, because there is no place to send them.

Too many homes for the aged are still boarding houses, with no medical facilities and no medical program. The modern home for the aged provides good medical care to its residents, with infirmary care for acute illness, and transfers to the general hospital only such cases as need surgical or other complicated treatment. The aged sick can be cared for more economically in the home for the aged than in the general hospital. A patient who has been transferred to the hospital can be quickly readmitted for post-operative dressings or convalescent care in the home's infirmary. The alteration of homes for the aged into auxiliary medical facilities is an important task for many communities and, with minimum expenditures, it will solve many of the medical problems of the aged.

Mild, undisturbed psychiatric cases can be cared for in a well-staffed home for the aged far better than in many a state hospital. We have a large and favorable experience at the Home for Aged and Infirm Hebrews in admitting old men and women who have been discharged from state hospitals. We have within the year readmitted two old men who were temporarily transferred to mental hospitals because of suicidal attempts. They have both done well.

An extremely important medical and social development is the extension of the home-care idea to the aged. Since the number of the handicapped aged is increasing far faster than institutional beds can be built, it is clear that they must be taken care of at home. In fact, only a small percentage of the aged are actually in institutions. Up until recently such old people at home have depended on family help, kind neighbors, and that marvelous organization, the Visiting Nurse Association. Miss Marian Randall, Director of the Visiting Nurse Association of New York City, recently informed me that, in the first six months of 1950, her nurses visited 4,000 patients over sixty-five years of age, making some 53,000 visits to this group.

These sick old people, however, have other pressing needs which are met in part by the excellent program of the New York City Department of Public Welfare. In a home-care program initiated two years ago by the Home for Aged and Infirm Hebrews, we look after our clients with visiting social

workers, physicians, homemakers supplied by the Community Homemaker Service of the Jewish Family Service, visiting nurses furnished by the Visiting Nurse Association, and volunteer friendly visitors.

The case-work agencies have made the interesting discovery within recent years that case-work with the aged is profitable and worth while. The Community Service Society of New York has a long record of deep interest in the aged. The activities initiated by Mr. W. H. Mathews and carried on by Miss Ollie Randall have made history. We must not forget that the first counseling center for the aged was established in San Francisco in 1929 by the famous psychologist, Dr. Lillien J. Martin, and we shall see this plan develop steadily. Sheltered workshops give the able-bodied old man the opportunity for useful work that mostly has been denied him.

The greatest single contribution to the mental health of the aged was originated over seven years ago by Mr. Harry Levine, of the New York City Department of Public Welfare, when he established a recreation center for the aged, now famous all over the world as the Hodson Memorial Center for the Aged. Here old men and women, living alone or in crowded homes, meet daily in a congenial atmosphere, where friendship and understanding await them, where they can read, model, paint, play cards, or just sit and smoke in peace. The wonders worked in older people in these centers, which are multiplying rapidly, can best be expressed in the story of the old lady who was going through her handbag and pulled out a card, saying to the worker, "Look, here's my clinic card. I clean forgot my appointment." These Hodson Center guests are not only happier, but actually seem healthier and far more free from the complaints of old age than others.

The rôle of the church in fostering the mental health of the elderly is appreciated with growing interest. Nothing sustains like true faith and no comfort can rival that offered by religion. Pastoral counseling and guidance must take their place along with the efforts of the social worker and the physician in caring for old people. The pastor may be of great value in interpreting the old person to his own family.

I wish to commend to your particular attention a splendid new work on this topic—"*Older People and the Church.*" by

Paul B. Maves and J. Lennart Cedarleaf,[1] who say, in their preface, "We are only on the threshold of the knowledge of aging and older people, and of the potentially creative relationship between those in later maturity and the Christian churches. Our book is, therefore, not definitive. But we hope it may initiate a vision, inspire a program and provide some operational principles which will eventually help all older persons to add life to their years." This is the work of great spiritual leaders, not only trained in theology, but familiar also with the teachings of modern medicine, psychiatry, and social work. Their book transcends creeds and should be studied by all who are interested in old age.

Since a successful mental-health program necessarily depends on sound community organization I wish to emphasize the broad basis upon which such a community effort must be founded. Perhaps I can make this clearer by describing the make-up of the First National Conference on Aging in Washington in August, 1950. This historic gathering included physicians, nurses, and social workers, biochemists, economists, psychologists, sociologists, anthropologists, educators, labor-union representatives, business leaders, consumer groups, priests, ministers, and rabbis. The problems of old age affect every community group and nearly every welfare agency. I recently counted the agencies in New York State and New York City that were concerned with the aged and found fourteen on the state level, and fourteen public and fifty private agencies on the city level.

I would recommend to all those concerned with community efforts, two recent publications: *Planning for Health Services —A Guide for States and Communities,* issued by the Public Health Service of the Federal Security Agency, and *Community Action for the Aging,* issued by the Committee on Aging of the New York State Association of Councils of Social Agencies, New York City. The first deals with general health planning, the second with specific problems presented by the aged.

One basic principle must be borne in mind by all who are interested in community action. Plans cannot be handed down

[1] Nashville, Tennessee: Abingdon-Cokesbury Press, 1949.

from on high. All planning must stem from a general desire for action in a specific community by interested individuals and agencies. The expert can stimulate and guide, but must never dictate or assume arbitrary attitudes. Further, every effort must be made to integrate existing agencies, to work within the framework of functioning bodies rather than to set up new organizations and thus further complicate our already intricate structure of welfare bodies.

My remarks would be sadly incomplete were I to neglect to emphasize the real pleasure and satisfaction to be derived from work with the aged. Too many physicians, nurses, and social workers have in the past allowed their sense of frustration at not being able to understand the aged to be projected as resentment against old people. Those of us who have worked with the aged know how challenging and stimulating this work can be, what wonderful patients old people are, how appreciative they are of small attentions, and what marvelous results modern medicine and surgery, as well as psychiatry, can achieve even in the highest age brackets.

We have the knowledge and the methods to make real and worth-while contributions to the mental health of the elderly. All that is lacking is the organization of our efforts in our own communities to follow established patterns and to pioneer in new ways. In this way—in the near future—the later years may truly become, in the words of Walt Whitman, "The teeming, quietest, happiest days of all, the brooding and blissful halcyon days."

A PUBLIC-HEALTH APPROACH TO CHILD PSYCHIATRY

AN INTRODUCTORY ACCOUNT OF AN EXPERIMENT

GERALD CAPLAN, M.D., B.Sc., D.P.M. (ENGLAND)
Psychiatric Director, Lasker Mental Hygiene and Child Guidance Center of Hadassah, Jerusalem, Israel

AS long as the suffering of the child or the disturbance he causes in his family and in the community controls the flow of cases, the child-guidance clinic will continue to be mainly a therapeutic institution, and prophylaxis must remain a subsidiary issue. Moreover, by the time the child's disturbance has reached such a pitch that his parents are willing to bring him for help, the therapeutic problem can be solved only by the expenditure of much time and effort. Even with group therapy, no community can afford to pay for enough psychotherapists to cure all its neurotic children. The community, nevertheless, demands that a clinic that it subsidizes should deal effectively with the cases that disturb it.

This pressure may drive the clinic to handle large numbers of ill children. They crowd its waiting rooms, and the most that can be done for them is to put a name to their disorder and give helpful advice on environmental modification. If, on the other hand, the clinic succeeds in resisting community pressure, and limits its intake to a number of cases that will not overload its therapeutic resources, only a small fraction of the disturbed children in the community can be given adequate treatment, while the vast majority are unaffected by the clinic's activities.

Both diagnosis and disposal for the many and therapy for the few are very valuable services, but they do not represent a major contribution to the fundamental problem of reducing the incidence of psychological ill health in the community. Many clinics realize this and allot a proportion of their time to community education. It is, however, doubtful to what extent lectures to parents and seminars for profes-

sional workers are successful in producing the major cultural changes necessary to alter the basic approach to children. This type of propaganda may even aggravate the practical problem by raising the clinic's prestige and adding even larger numbers of neurotic children to its swollen waiting lists.

In September, 1949, an experiment was started at the Lasker Center in Jerusalem to investigate the feasibility of a different approach to this problem. The program broke away from the orthodox rôle of providing therapy for the suffering patient, and concentrated instead on a search for pathogenic emotional factors that have not as yet manifested themselves in serious behavior disorders and that are capable of rapid alteration through intensive methods of treatment. Instead of waiting for patients already aware of their illness to enlist its services, the center now chooses its clients according to its own criteria. In cases of parents whose relationship with their children is pathogenic, this method of choice permits contact with them before serious damage has been done. If the process can be detected in its earliest stages, the child's mild disorder may require no special treatment. The amount of treatment needed for the parents, if they are carefully selected, may be such that a small team of workers can handle a large number of cases and make a significant contribution to the promotion of mental health in the child population.

It is a fundamental concept of the new program that although the selection of clients is not based on their desire for treatment, the therapeutic rôle is strongly emphasized in handling those that are accepted. It is felt that effective amelioration of pathogenic attitudes must involve face-to-face contact between worker and client, and must operate on the basis of a key emotional relationship between them.

In addition to direct work with parents, it was decided to try to influence the community through the medium of other professional workers. To prepare them for this rôle, it was planned to involve them actively in the program as part of the team of mental-health workers dealing with the selection of cases and their treatment. It was hoped that in this way they could be helped to acquire mental-hygiene insights and techniques which they could not obtain through orthodox seminars and case conferences.

The decision not to wait for ill children to be referred, but to go out and contact them in the first stages of psychological disturbance, presented an immediate practical problem. It was associated with the search for key situations in which the efforts of the mental-health workers could produce the greatest results in the way of community change.

The problem was met by beginning the work, not in the Lasker Center itself, but in the community health centers. These centers, which were established by the Hadassah Medical Organization thirty years ago in the various districts of Jerusalem, combine the functions of prenatal clinics and infant-welfare centers. They fulfill a preventive medical function in relation to the child, from its mother's pregnancy right through to kindergarten age. Each center handles from 800 to 1,000 families in its immediate neighborhood, and as a result of active work over many years, has become firmly established in their confidence. Parents turn readily to its nurses and doctors for guidance in problems of pregnancy and child care; and the specially trained public-health nurses make regular visits to the homes of the member families, performing the functions of health visitors and social workers.

The psychiatrist and two psychiatric social workers of the Lasker Center have, during the year, worked intensively with three neighboring health centers of this type, and have been available for consultation in two other centers in more distant parts of the city. They have entered the centers as members of their staff; and by closely coöperating with the pediatricians, obstetricians, and nurses, they have been able to make contact with expectant mothers and with parents of selected infants and young children.

The work with expectant mothers has been described elsewhere,[1] and will not be dealt with here. It may, however, be emphasized that during pregnancy a woman is in a state of emotional crisis, and is in an appropriate condition to have her attitude to her future child molded by methods that entail a minimum expenditure of time and effort. Also, the ease with which she identifies with other pregnant women permits advantage to be taken of group techniques, which

[1] See "Mental-Hygiene Work with Expectant Mothers," by Gerald Caplan. MENTAL HYGIENE, Vol. 35, pp. 41–50, January, 1951.

are more potent than individual methods in producing changes of attitude in short-term contacts.

In the infant-welfare centers, the initial contact with the parents is made by the psychiatrist. During the first year, the initiative for the choice of cases has been largely left with the nurse and the pediatrician, in the hope that their long experience of the usual abnormalities of childhood will enable them to single out those children whose symptoms, though still slight, point to the possibility of more serious trouble in the future. The practice has been that mothers who, during a routine health check-up, complain of difficulties with their children are referred by the nurse to "one of our doctors who deals with such matters." The mother is thus ushered without ceremony into the psychiatrist's room, and is not aware beforehand that he is a psychiatrist. This routine obviates the initial arousal of anxiety and resistance, and insures that all selected mothers attend the first interview.

An interview technique has gradually been worked out which allows the psychiatrist to obtain a superficial picture of the personalities of mother and child, and the emotional interrelationships of the home, without arousing the fear that this is anything much out of the ordinary routine of the infant-welfare center. The psychiatrist is then faced with the difficult task of making a provisional diagnosis on the basis of this somewhat inadequate information. This has to be done during the course of the first interview if possible, in order to determine the subsequent conduct of the session. Delay usually leads to the arousal of resistance and non-attendance at the second appointment. The diagnosis involves an appraisal of the type and degree of the child's disorder and also of the quality of the mother-child relationship, with a view to a judgment on prognosis.

The psychiatrist may feel that the emotional atmosphere in the home is fairly average and that the relationships between parents and child are reasonably healthy. He may decide that the child's symptoms are mainly due to one of the common emotional disorders of development, perhaps exacerbated by parental anxiety and unwise handling. In this event he will probably feel that the case will resolve without much active therapeutic interference, and he will terminate the contact in one or two sessions. He gives the mother

information about the child's present developmental stage and future line of development; he reassures her about the normality of minor emotional upsets and symptoms, reduces her anxiety and guilt, and perhaps gives her helpful advice on handling behavior problems in the light of the knowledge he imparts.

Similar treatment by reassurance, education, and advice is given if the psychiatrist is faced with a problem of obviously very poor prognosis, which he does not feel can be adequately dealt with in the Lasker Center framework or in any other psychiatric agency available in Jerusalem. This course has been followed only rarely in cases where the parents are grossly disturbed, or where there are major social problems, for which they are referred to social-work agencies.

The majority of cases seen have been judged to be intermediate in severity. In these cases, mild or moderate disturbance has been identified in the personality of the parents and in their relationships with each other and with the child; and the latter's symptoms have been felt to be the first signs of a disturbance that will get progressively worse unless the pathogenic factors are modified. These are the cases that have been taken on for treatment by the Lasker Center.

It was quickly realized that the task of insuring that such clients begin treatment is one of considerable difficulty and delicacy. The mother makes the initial contact without any felt need for special treatment. Her child's minor symptoms do not worry her very much. They are certainly not enough to force her to overcome her natural defenses against laying bare her emotional life to a stranger. And, in addition, she probably has a deep prejudice and fear of anything that has to do with psychiatry, which to her is associated only with the stigma of mental illness.

Apart from such superficial causes of resistance to beginning treatment, there are many deeper factors which are unconsciously determined. The mother may be deriving sadomasochistic satisfaction from her struggles with the child; or her handling of him may represent the acting out of some other unconscious conflict. The parents may be utilizing the child as the battleground of their mutual antagonisms; or his symptoms may be effectively masking their own difficul-

ties—as when their sexual disharmony is hidden by the demands of his sleeping rituals.

Such resistances are commonplace in ordinary child-guidance practice, but since the parents come to child-guidance clinics with the consciously expressed desire for therapy, those with the most superficial or the strongest resistances never reach the clinic. In the present work a more comprehensive sample of cases is available, and this has focused attention on the importance and the varied nature of these obstacles to treatment. Much thought had, therefore, to be given to the working out of a technique to insure that the chosen cases would not be interrupted in the early stages of intake.

Experience showed that reassuring formulations in the first interviews lessened the mother's anxiety and brought about interruption of contact by reducing the incentive to return. This was particularly the case before the mother had developed a positive emotional relationship with the therapist, which itself acts as the major bond in maintaining contact.

This knowledge has led to the directed use, during the first interviews, of formulations that augment the mother's anxiety. Of course no attempt is made to frighten her, but she is confronted with the reality situation of the meaning of the child's symptoms. The implications in regard to his future life are pointed out in the event that nothing is done to halt the process, and the future disturbance in the home and in school is discussed.

Such formulations, which increase the mother's anxiety, usually lead to an acute increase of her guilt feelings. Unless these are immediately relieved by pointed discussion and active emotional ventilation in a non-critical atmosphere, she usually never appears again. No attempts at rational explanation and persuasion are likely to force her to return to some one who makes her feel guilty, and who, she is sure, must despise her after revealing her incompetence.

The third step in the technique consists in building up the mother's hope and confidence that, with the help that is offered her, she will be able to steer the child back into the line of healthy development. The ease of treating disturbances in their early stages, as compared with the difficulty and length of treatment later on, is emphasized, and she is

told that by discussing the child's problems now with an "expert in child care," she will be enabled to handle them herself.

The first interview concludes by working out with her an appointment with the psychiatric social worker, which takes place in the same room within the week. The mother's link with the agency is not usually strained at this stage by the suggestion that she should come to the Lasker Center itself; and care is taken not to use any psychological terms that might frighten her in relation to the initial procedure.

The psychiatric social worker arranges weekly interviews with mother and child in the infant-welfare center until a stable emotional bond has been forged, and only after consideration of the strength of this link and the nature of the case, is the suggestion made that the meetings be held in the Lasker Center. This may often be done in connection with an offer of accessory psychological investigation or supervision of the child; or, if he needs it, individual or group psychotherapy can be arranged. The latter is sometimes a condition for the continued attendance of the mother.

In selected cases, the mothers are not referred for case-work treatment by the psychiatric social workers, but are seen a few times for short interviews by the psychiatrist and are prepared for transfer to the Lasker Center for group therapy, which the psychiatrist carries out along superficial analytic lines.

Meticulous attention to detail in this contact and intake procedure has shown, in nearly a hundred cases during the course of the year, that selected mothers can be successfully taken into treatment despite the fact that they did not originally apply for it. It has, however, proved much more difficult to bring some fathers into treatment in this setting, and this is a problem that still awaits solution.

The types of treatment used so far have been similar to those carried out in many psychoanalytically oriented child-guidance clinics; but it is intended to try to develop modified techniques, with the object of shortening the procedures to the minimum necessary to produce the required therapeutic effect.

Usually the parents alone have been treated, but in some cases of older children, where it appears that neurotic changes

have already begun, or where coöperation of the parents would otherwise not be obtainable, the child also has been accepted for individual or group treatment. This therapy has been carried out in the center because facilities have not been available in the infant-welfare clinics.

In cases in which the pathogenic factor in the child's situation is associated with problems of marital disharmony, the parents have been treated by the psychiatrist through the medium of joint interviews. These have been conducted along group-analytic lines, and have resulted in rapid releases of tension between the parents, with in some cases a resulting fundamental change in their attitude toward each other and toward the child.

The majority of cases have been handled by the psychiatric social workers by case-work treatment of the mother, and occasionally also of the father. In dealing with the mother, the well-being of the child is emphasized as the goal of treatment. Invariably the mother's own emotional problems come up for discussion, but they are dealt with only in so far as they are directly related to the problems of the child. The child, therefore, remains the patient even if the mother alone is seen, and this represents one important difference between such a technique and psychotherapy proper.

The worker restricts the discussion to the narrow field involving the problems of the mother's emotional relationship to her child; and the goal is to help her develop freedom to behave toward him in accordance with the reality of his individual identity and needs, instead of handling him by methods distorted by unconscious identifications and guilt phantasies. Guilt associated with attempts at abortion has been a common finding, and among the more usual identifications have been those with the mother's "bad self," with her husband, with her parents or siblings, or with older children who were ill or who died before this child was born.

Through the uncovering and making conscious of such identifications and phantasies, the child may be freed from involvement in the mother's emotional conflicts, and may cease to be exploited in their partial solution through "acting out."[1] The

[1] The theory is that a person maintains emotional equilibrium by finding various "part solutions" for his conflicts. Some of these solutions operate in the sphere of consciousness and reality and can be classified as non-neurotic;

ease with which this therapeutic process is accomplished seems to depend on the economic importance of this acting out relative to the mother's total equilibrium of conflicting emotional forces. It was originally expected that it would be quicker and easier in mothers with the most healthy personalities, and in cases in which the disorder in parent-child relationship was produced by accidental environmental factors, such as the death of an older child during the pregnancy with the present child. This has to some extent proved true in practice, but it has also been discovered that, even in some quite disturbed mothers, the therapeutic "unlinking" with the child may be accomplished with relative ease. The operative factor seems to be the degree of rigidity in the mother's personality rather than the extent of her own disturbance.

The relative importance of the distorted pattern of the mother-child relationship as a part solution of the mother's conflicts has been found significant in the progress of the case after the disturbing phantasy elements have been uncovered. The greater the relative importance of this part solution, the more is the mother's emotional equilibrium upset by the localized therapy of this directed case-work. She may then seek equilibrium by new neurotic part solutions involving another member of the family, such as another child; or she may herself develop fresh overt symptoms. Both these eventualities are to be avoided, even though the latter may lead to her demand for psychotherapy for herself. In view of the shortage of psychotherapists, it can only very rarely be a proper mental-hygiene goal to complete a child-guidance case by referring the mother to an adult clinic.

In order to solve these problems, a modification in technique is being worked out that involves a change-over from the analytic to a supportive approach as soon as the mother's relationship with the child has been freed. With increasing experience, this stage in the treatment process is becoming easier to identify. One good sign is the sudden development by the mother of the ability to make successful use of advice.

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others involve the production of overt neurotic symptoms; others are crystallized in neurotic personality traits; and some result in the acting out of unconscious phantasies in relation to people in the environment who are manipulated into playing significant rôles. The economic ratio of these different part solutions at any time largely determines the state of psychological health.

She can now profit by an intellectual understanding of the child's disorder of behavior, so that she can handle it on a reality basis, whereas previously her emotional involvement blocked or perverted this process.

Another important contribution to the solution of these problems may lie in more appropriate selection of the clients accepted for case-work treatment. Only after a year's work did it become obvious that the original approach of selecting mothers for treatment mainly on the basis of mild signs in the child was not a logical way of insuring that they would be the best subjects for short-term therapy. If selection for treatment takes place immediately after the initial interview, which cannot yield adequate information about the mother's personality, many clients will be included who will later prove to be unsuitable, with a resultant wastage of therapeutic endeavor. It has, therefore, been decided to delay the decision on treatment plan until the psychiatric social worker has seen the mother a few times for exploratory discussions. During this period it is possible to gather the essential data for a more refined selection procedure.

The process of the case-work treatment as practiced at present can thus be summarized as falling into three phases. There is an initial period during which the psychiatric social worker aims at building up an emotional link with the mother. The latter is offered the opportunity for a quite new type of emotional relationship with some one who understands her problems with the child and who does not judge or criticize her. She is thus enabled to lay aside her usual defenses against real contact with another person, and can expose and acknowledge more of herself than before.

This permits her to enter the second phase of treatment during which she brings up pre-conscious material relating to the influence of her past experience on her present attitude toward the child. This phase continues until the main obstacles to her being able to relate freely to the child as a separate individual are uncovered and removed. It is doubtful whether the development of insight is an essential step in this process, or whether the problem cannot be successfully worked out in her emotional relationship with the worker while her past experience is being discussed.

The third phase consists of working through this material, and seeing it in outline in relation to herself as a person with emotional problems that have to be solved during the process of living. The worker helps the mother to realize the limitations of outside assistance in the solution of her problems, and gives her reassurance in regard to her anxieties and fears. The mother is supported in building up a resolve to make the best of her native capacities, and in coming to a decision to permit her children to develop in their own way without involving them in her own inner conflicts.

It is planned that if the review of the case at the end of the first phase reveals undue rigidity in the mother's mental functioning, or if the nature of her problems is such that relieving the disorder in the relationship with the child may precipitate a more serious therapeutic difficulty, the second phase will be omitted. The case will then be closed by a period of reassurance and follow-up supportive contact.

In addition to this individual case-work treatment, a suitable method of superficial analytic group psychotherapy for the less disturbed mothers is being investigated. Groups consisting of about six mothers meet once a week with the psychiatrist for discussion of the emotional problems of their children and their methods of handling them. The main technical problem is to find out at what depth the psychiatrist should work. Too much didactic activity on his part results in a superficial and merely intellectual effect. On the other hand, transference interpretations and stress on analysis of intra-group tensions lead to unwelcome involvement with the deeper personality difficulties of the participants. The problem has gradually taken on a shape similar to that encountered in the work with individuals—namely, how to give short-term therapy that will be potent enough to effect a radical alteration in the mother-child relationship without the therapist's being forced to undertake treatment of the mother's general emotional difficulties.

It is hoped that, on the basis of dealing with the individual disturbed child, his mother's insight can be enlarged, and her attitude, not only to him, but to her other children improved. The same child also serves as a stimulus for work with the public-health personnel of the health center, who may then spread the benefit to other children.

The doctors, nurses, and social workers who are involved in the case are drawn into active participation by frequent individual and group discussions during its progress. Didactic theoretical dissertations are scrupulously avoided, and much of the contact is kept on an informal plane in the form of short verbal reports and discussions between the workers at each visit to the infant-welfare center. Care is taken not to arouse undue anxiety by too detailed descriptions of the unconscious mechanisms of the case, and intimate material is not divulged. The latter point is important as a practical example of the mental-hygiene principle of the non-authoritarian approach, which stresses respect for the individual dignity of the client.

In addition to the informal discussions in the infant-welfare clinics, it has been possible to arrange a regular seminar for public-health nurses and pediatricians. This has taken the form of a workshop discussion group which has dealt with current cases from the clinics and also with problems of psychopathology and techniques. The latest ideas on the planning of the work have been constantly brought up for discussion in this group, so that a team spirit has been fostered among the workers in the various fields. This has led on all sides to modifications of attitudes. The nurses and pediatricians have softened their previously rather rigid and authoritarian approach. And at the same time they have been able to help the mental-health workers realize more realistically the implications of the range of normality in the reactions both of parents and of children. The mixed group has also helped to clarify the necessity to adapt Western techniques to the different needs of Jerusalem, with its varied population of European and Oriental people.

Two other phases of the program have been of help in building up an atmosphere of understanding of mental-hygiene principles. At each group meeting of expectant mothers, one or more of the nurses were present, and thus had an opportunity of seeing the mental-health workers in action. These meetings usually stirred up considerable interest and often anxiety in the nurses, especially when the worker was more permissive than they had been and led the mothers on to open emotional ventilation. An attempt was always

made to deal with these anxieties and doubts after the group meeting, and these "working through" sessions were felt to be of value in increasing the insight of the nurses into the nature of the mental-hygiene process.

Another valuable contact with the nurses was afforded by a follow-up investigation which was started toward the end of the year. Their coöperation was enlisted in cases from their own infant-welfare center, and because of their intimate knowledge of their member families, they were able to be of great help in planning the home visits to be made by the psychiatric social workers. During these visits an attempt was made to gather a maximum of dynamically meaningful information, and this was later discussed with the nurses. They were thus enabled to correlate the follow-up findings with their own previous evaluation of the cases and with the opinions and treatment procedures of the Lasker Center.

During the course of the year, a community of feeling and a common language have begun to develop between the psychiatric staff and the public-health workers, and it is hoped that the latter will be able to assimilate some of the mental-hygiene principles and to remold their own day-to-day work. They come into contact with many parents and children during key periods of their lives, and it is hoped that, with their developing insights, they will exert a growing mental-hygiene influence on these clients without needing to refer many of them for specialist treatment.

The present account represents a preliminary crystallization of work in progress, and the views expressed, in regard both to selection and to treatment, are of a tentative nature. It is expected that they will be broadened and modified as the investigation continues, and as they can be based on richer experience and more reliable findings.

Clinical impressions so far have been in conformity with the findings of Friedlander (1946),[1] Fries (1946),[2] Joseph

[1] See "Psychoanalytic Orientations in Child Guidance Work in Great Britain," by Kate Friedlander, in *The Psychoanalytic Study of the Child*, Vol. 2. New York: International Universities Press, 1946.

[2] See "The Child's Ego Development and the Training of the Adults in His Environment," by Margaret E. Fries, in *The Psychoanalytic Study of the Child*, Vol. 2. New York: International Universities Press, 1946.

(1948),[1] and Jacobs (1949) [2] in regard to the surprising ease with which short-term methods achieve good therapeutic results in disturbances of mothers and children in infant-welfare centers. It is hoped that a follow-up investigation that has lately been started may confirm these results, and may also be of assistance in improving selection and treatment procedures.

All cases completed during the year have been investigated, and it is planned to repeat the follow-up on these and future cases at six monthly intervals. As soon as selection and therapeutic techniques have been stabilized, it is planned to follow up a control group from each of the infant-welfare centers, if possible by means of alternate sampling, which may become practicable when the number of cases selected is sufficiently large.

By repeating the follow-up at intervals over a prolonged period, and by correlating the results with the case records in the infant-welfare centers and with the information obtained from the nurses, it should be possible to build up a dynamic picture of the process of the child's development and assess the significance of the therapeutic intervention.

Each follow-up investigation is based on visits to the child's home by a psychiatric social worker, and wherever possible, the child is also observed by a psychologist in the kindergarten, and his condition is discussed with the nurses, pediatricians, and kindergarten teachers. At the home visit, which lasts at least an hour and a half, an open-ended interview technique is used to obtain relevant information from the parents. In all except one or two cases, the family has welcomed the visit as evidence of the continued friendly interest in their problems, and has coöperated fully in the investigation.

In addition to a full process record on the home visit, the worker fills in a summary sheet which classifies the material

[1] See "A Psychiatric Social Worker in a Maternity and Child Welfare Center" (*British Journal of Psychiatric Social Work*, Vol. 2, 1948), and "A Technical Problem in the Treatment of the Infant Patient" (*International Journal of Psychoanalysis*, Vol. 29, 1948), both by Betty Joseph.

[2] See "Methods Used in the Education of Mothers. A Contribution to the Handling and Treatment of Developmental Difficulties in Children under Five Years of Age," by Lydia Jacobs, in *The Psychoanalytic Study of the Child*, Vols. 3 and 4. New York: International Universities Press, 1949.

under the following headings: present psychological condition of the child, of the mother, of the father, and of the siblings; socio-economic condition of the home; present condition of the emotional relationship between mother and child, father and child, siblings and child, father and mother; assessment of the severity of the child's disturbance before, during, and since the period of treatment; conscious and unconscious attitudes of the parents to the Lasker Center and the infant-welfare center, with special reference to their experience during intake, treatment, closure, and follow-up.

This procedure is itself being elaborated and modified, but experience so far has shown that even in its present form, it can be used to build up a fairly comprehensive picture of the emotional condition of the child and his family, with indications of the temporary and permanent effects of their contact with the center.

APPLYING GROUP THERAPY TO CLASSROOM PRACTICE

HENRY S. MAAS

Assistant Professor, Committee on Human Development, University of Chicago

CLASSROOM teachers are concerned to-day with helping students to develop skills in understanding themselves and others as human beings—their needs, motives, and behaviors. A variety of methods have been proposed for the teaching of such skills, some procedures, such as classes in "family living," being of a frankly didactic and logical nature. Aside from techniques like "rôle-taking,"[1] no clearly formulated method described in the literature makes use of analyses of interpersonal situations in the classroom; and even in "rôle-taking," the situations are drawn from life outside the classroom rather than from the natural processes in the life of the class.

The proposal made in this paper for a three-stage sequence of training, aimed at developing among young people an understanding and an acceptance of others and of themselves, grows out of the writer's research in group psychotherapy and his own classroom teaching experiences. This is not the place to expatiate on all the similarities between group psychotherapy and formal education; to indicate how they are related social processes, but essentially quite different in objectives; to describe the development of either group-life or therapeutic processes as they may be patterned in the course of long-term group psychotherapy; or to distinguish in detail between psychotherapy and formal education as socio-psychological processes. The purpose of this article is simply to describe objectives and procedures for the application of some aspects of group psychotherapy to classroom practice in (1) the primary school, (2) the intermediate grades through early

[1] See "Sociodrama as Educative Process," by Helen Hall Jennings, in *Fostering Mental Health in Our Schools.* (Yearbook of The Association for Supervision and Curriculum Development.) Washington, D. C.: National Education Association, 1950. pp. 260–85.

junior high school, and (3) junior and senior high schools and the college years. This is the three-stage sequence. This program is offered provisionally, a proposal to be tested in various school settings. It capitalizes on the interpersonal or group processes in classroom life.[1]

An Approach in Early Formal Education.—The child's entry into school society marks his first organized contact with many others like himself, all under adult leadership. The teacher may expect children to explore the boundaries of this new situation. Such exploration may be apparent in the way children challenge or seek approval from the teacher, in the rivalries among the pupils, and in the striving for status among some of them. Behavior on the part of individual pupils that runs counter to the purposes and progress of class activities may be frequent. Much of this behavior may be considered evidence of the children's feeling alone, unrelated, or uncomfortable with their classmates.

At this period, teachers try to establish customs for the group and to give emotional support to individual pupils as they express feelings about their experiences of a frustrating or otherwise disturbing nature. These upsetting experiences may be part of the children's current interpersonal relationships in the classroom or of situations at home or elsewhere. The teacher's focus is usually on the individual.

One technique at this early level of school life that makes use of the group nature of the class and that grows out of practice in group therapy is the following: *the teacher may foster the transient linking of pupils who evidence similar feelings or report on similar circumstances.* The primary-school teacher may try to communicate to pupils not only such themes as: "It is all right to express feelings here," and, "I can understand your feelings," but also, "That is just like what Bob and Alice feel. I guess many of the children (your classmates) feel that way, too."

To be able to convey these ideas to pupils, the teacher probably will have to consider the general image she presents—one preferably that is nonpartisan and that avoids identification either with parents or with children. When, for example, as the teacher is about to start the phonograph, a

[1] See "Understanding Group Processes," by Henry S. Maas. *Ibid.*, pp. 286–99.

primary-grade child complains that her mother will not permit her to bring a set of records to school, the teacher may (1) join, in the child's eyes, the adult block that values things more than children when she says, "Well, Mother knows best!"; (2) identify with the child against parental decision by inquiring under what circumstances the records might possibly be brought to class, and, finding none, implicitly sympathize with the child about the cruel restraints of her parent; or (3) identify with neither child nor parent, but solicit similar expressions of feeling from others in the class (when Joe and Sue volunteer similar stories of parental prohibition) and then generalize for all, "Mother sometimes treats us like we're not so grown up as we feel. Joe and Mary and Sue all feel that way."

In the last approach, the teacher tries to make apparent her appreciation of the community of feelings among a few members of the class. Focus remains chiefly on the *many* children present. Mary, who singles herself out, is linked to others. Her feelings of uniqueness are matched with others' similar feelings. Only as some of the children's negative feelings are ventilated, accepted by the adult, and associated with the feelings of their classmates can these pupils be enabled to participate fully in subsequent educative activities.[1]

In general, the primary teacher may try to offer such emotional support as will meet children's varying needs for constructive relationships with an adult. Also, however, the objective is that in time, through this hierarchal (child-adult) relationship, the capacity for lateral (child-child) relationships in the class will develop healthfully. Linking of pupils with common feelings in the manner described here is one method that may help toward this end, too.

An Approach in the Middle Grades.—Before the end of the primary grades, subgroup formations of a relatively stable

[1] For a discussion of "non-curtailment situations in which feelings might be expressed" among preschool children, see "Incorporation of Therapeutic Procedures as Part of the Educative Process," by Dorothy W. Baruch (*American Journal of Orthopsychiatry*, Vol. 12, October, 1942. pp. 659–65). For a kindergarten situation, see "Education as Therapy," by Augusta Alpert (*Psychoanalytic Quarterly*, Vol. 10, 1941. pp. 460–74). For a study of a type of group-therapy program in the primary grades, see "Group Therapy and Social Acceptance in a First-Second Grade," by Ruth G. Davis, (*Elementary School Journal*, Vol. 44, December, 1948. pp. 219–23).

nature should appear among the pupils. In this process there are likely to be considerably mixed feelings about separation from the adult, manifested in subgroups determined to play and to avoid work, as well as in others that most of the time seem eager to get to work. Support from classmates, as the capacity for close two-way relationships with peers develops, may help to make the adult a less significant person and the need for adult approval less important. Irritation or anger with the adult may be more openly expressed if such expression is not taboo in the classroom. The development of peer relations may further the teacher's long-range objective to share more and more of the responsibility for planning and programing with the pupils in their own subgroups.

During the intermediate grades and in early junior high school, didactic study of human behavior may be possible. This is an introduction to the type of thinking that may be applied to immediate classroom situations in later grades. It is a sort of demonstration of skill by the teacher. The subjects of the demonstration are not at this time members of the class; they are contemporaries in literature, or a "make-believe" boy or girl in a discussion period. Conscious procedures for understanding the other (and, implicitly, oneself) are being practiced. During this period—which has been called "pre-adolescence," and which is characterized by (1) movement from self-centeredness to a social state, (2) a new view of the world, (3) a new human feeling with the maturation of the initial capacity for love, and (4) a deep interest in sharing and confirming with age-mates one's ideas about life —curiosity about others as people is great, too.[1]

For example, during this period the members of one class, in studying "our neighborhood," visited a local store where the proprietor told of recent thefts. Some of the children raised questions as to why people steal. The teacher used this as a lead to discuss some aspects of human behavior with them. While the discussion opened with questions about stealing and then turned to murders, which currently filled the tabloids, the teacher redirected them to a consideration of how feelings motivate young people in simpler situations. One boy brought up the anger of a "make-believe friend"

[1] See *Conceptions of Modern Psychiatry*, by Harry Stack Sullivan. Washington, D. C.: William Alanson White Psychiatric Foundation, 1947. pp. 19–21.

who was pushed into a mud puddle. Why did he feel as he did? Why did he get up and hit the other boy? The teacher helped the class to consider who was present at the time of the incident, and what the total psychological situation was in terms of surrogates in the boy's perception at the time. Parents, siblings, and other significant people became dotted-line (ghostlike) images on the blackboard. Interpersonal relations were analyzed in that *specific situation* with reference to immediately present, recently past, and future feelings. Class discussion was widespread and eager. Personal references were "disguised" as, "supposing a girl . . . " Acceptance and understanding of the feelings of others and awareness of self in relations with others were the implicit objectives.

In both group development and educative processes, classes at this period may resemble a therapy group in its second phase. One may find subgroups oriented toward support of the teacher and of educative work objectives. Again, one may find subgroups openly concerned with their negative feelings toward adults. Members of these subgroups may find support in their relations with one another, and, therefore, be better able to express their feelings. If the teacher during this period can convey an acceptance of the expression of such feelings, within limits, there is increased likelihood that the school may continue to be regarded as a place where (1) feelings are valued and (2) the self is esteemed. One may expect acceptance of self to spread to acceptance of others.

Situation Analyses in Later Phases of Education.—During later junior high school and through the remainder of formal education, emotional support and acceptance by teacher and occasional didactic analyses of troublesome situations occurring outside the group may be supplemented by the examination of interpersonal behavior and relations in *specific situations in the classroom.* The situations chosen for analysis are those in which resistance to class progress is manifested. An assumption here is that class direction at this stage is determined jointly by pupils and teacher, so resistance is by no means uniformly confined to work objectives or processes that are identified completely with adult authority. When such resistance situations arise, a non-critical and properly

timed analysis may be made of what has been going on in the class.

This study of behavior in the group learning situation becomes a major learning experience itself. Its objective is to increase the individual's awareness of his own relations with others, of the attitudes he arouses in others, and of the attitudes in himself that motivate his behavior. This may be accomplished without direct attention to the private and personal aspects of the life of any individual. Focus is on the present interpersonal processes—the "sociodynamics" in the resistance situation. What the individual learns about himself as an individual may well be a private by-product of this group analysis. From the repeated examination of resistance situations in which certain members of a class time and again fill certain niches in the group processes, the individual's awareness of his own dynamics and of the attitudes of others may increase.

A resistance situation in a classroom is a situation in which the group's academic learning activities are blocked. Some manifestations of this are feuds, apparently inappropriate affect, avoidance of or attempts to deny responsibility for work in progress. In a ninth-year class, for example, one student began rather violently to attack the student chairman. The attack was joined in heatedly by two others. The student chairman was defended by a fifth student.

The teacher allowed the feud to continue until the class was manifestly uneasy about what was going on. She then remarked, as a matter of observation, that the class did not seem to be moving along as it might wish. She wondered what was happening.

During the subsequent discussion, as circumstances in the situation were being reviewed, the student who had initiated the attack remarked that the chairman had not organized the lesson well enough. The teacher wondered whether this was a criticism of the chairman, or perhaps of herself for not having taken over the lesson. One of the students who had been active in the attack on the chairman then remarked that he felt, since the students paid tuition in this school, they ought to have a teacher who was competent enough to teach the class herself. The teacher accepted this comment; she

said she wondered whether there were not others in the class who felt this way, too.

After a silence, one of the students said she thought some people always needed some one to show them how to do things. When the teacher added that perhaps that some one always had to be a person who was supposed to know the answer, a sort of final authority, there was a pause, and then the discussion turned to how uncomfortable any one might feel when he wanted direction and did not feel that he was getting it. "He might even get real mad and fight with some one—like Rob and Lou did," one student said. Rob and Lou were sitting back quietly. Others added their observations. Then some one said, "Well, let's get back to work."

In the subsequent period, two of the three students who had formerly attacked the chairman participated with apparent interest as the latter continued to lead the discussion.[1]

This occurrence has in it many of the elements of a potentially effective situation analysis:

1. Obstructiveness to a group's educative procedure was expressed through inappropriate feelings—*i.e.,* feelings disproportionate to what the situation, objectively viewed, called for. The inappropriate affect made this a resistance situation, *not* merely the disapproval of what was going on in the class. (Thoughtful disagreement about classroom procedure is to be encouraged and should by no means be considered "resistance.")

2. The teacher did not intervene immediately, but waited for signs of dissatisfaction with the situation among members of the class.

3. Her comment then was uncritical and directed not at the individuals who had precipitated the situation, but at the apparent reactions of the class as a group.

4. She encouraged the students to discuss what they thought was going on. In the course of this discussion, the initiator of the resistance gave what he thought was the reason for his attack.

5. Having noted the inappropriateness of his feelings, the teacher interpreted tentatively that his anger was displaced —that it really was an attack on her. Even this she suggested

[1] This situation was observed in the Math 9-X Class of Mrs. Gladys Junker, Laboratory School, University of Chicago.

uncritically, realizing that this fifteen-year-old probably had no real personal grievance against her, but was working indirectly on his feelings toward adults or parent figures in general.

6. This accepting interpretation led one of the attackers to "explain" some of his feelings about the teacher's serving merely as a resource person rather than as the lone director of classroom activity. Perhaps he felt that no student (aside from himself!) should share in major responsibility for class procedure. Perhaps there were other motives for his attack. At this point, inquiry into this student's private and personal experiences and further investigation of his personal dynamics might reveal why he had so ostensibly strong a need for adult leadership. This, however, under other circumstances and in a different setting, would be within the province of psychotherapy. In the classroom, the general *meanings of interpersonal processes (sociodynamics)* rather than the causes of individual processes (psychodynamics) are the appropriate foci.

7. Accepting of this attack, too, the teacher encouraged others who had similar feelings to express them. She did not counterattack. In this situation, no other students expressed similar feelings. At another time, others might have.

8. A student in this class, having done some previous thinking about sociodynamics in this group, then gave a relatively uncritical interpretation of the meaning of the resistance behavior.

9. She was reinforced by the teacher, a perhaps unnecessary intervention, since adolescents generally consider more seriously the judgments of their peers than of adults. Others might have amplified the interpretation if she had remained silent. In this situation, though, the teacher probably had in mind the apparent dynamics of the initiators.

10. Subsequent discussion clarified for the group the feelings of students who are overdependent on authority for structuring their class work. Understanding the behavior and attitudes of others—and implicitly of the self in certain situations—was probably somewhat furthered by this focus. The accepting tone, moreover, of the students in the discussion probably helped two of the initiators in this situation to reënter group activity with a minimum of residual discomfort.

The extent to which they as individuals found this a personally corrective experience cannot here be estimated.

The proposal here is that analyses of sociodynamics may appropriately be used from later junior high school through college.

Experimental Use and Training Needs of the Program.—In current educative practice, an episode such as the one cited is rare. For an investigation of the effectiveness of analyses of resistance situations, appropriate, repeated, and long-term uses of this approach would have to be made in classes under study. Obviously, only in a school milieu that is sympathetic to the program could manifestations of resistance be tolerated long enough for the students and the teacher to observe, react to, and analyze the sociodynamics in the class.

The teacher in the situation cited was apparently a secure and quite intuitive person. Should further testing of these techniques reveal desirable effects, teacher education would obviously have to include training in this area. Such training might make appropriate use of situation analyses, as the need for them arose, throughout the normal training program, rather than in any formal course *about* this approach.

The teacher, of course, is a key person in any such program. His own broad tolerance for others and self-awareness are essential. On the college level, the effects of other orientations to the development of an understanding of self and others have been reported. Therapeutic gain has been claimed for a class in academic mental hygiene, but no description of classroom procedures is given beyond the inference that "of particular importance [to the students] was the relationship with the instructor."[1] Another college teacher, Cantor, has attempted to demonstrate changes among his undergraduate students as a result of a shared-responsibility approach to learning and of some analyses of relations between the students and the instructor, but he seems to have given little direct attention to student-student relationships in his classes.[2]

[1] See "The Therapeutic Value for Teachers of the Course in Mental Hygiene," by P. M. Symonds and H. R. Haggerty. *Journal of Educational Psychology,* Vol. 33, November, 1942. p. 565.

[2] See *Dynamics of Learning,* by Nathaniel Cantor. Buffalo, N. Y.: Foster and Stewart Publishing Company, 1946.

One final note of caution must be expressed about the methods described in this article. There is a growing tendency, particularly in undergraduate and graduate classes in psychology and the social sciences, for faculty members who have gained an acquaintanceship with psychotherapy to practice their therapeutic skills with students in their classrooms. Unquestionably, experimentation in education is needed. And education may profitably adapt some techniques from psychotherapy for its own purposes. But while formal education and psychotherapy include related processes, they are not at all equivalent or interchangeable. The rôles of teacher and of therapist may be allied, but they are far from identical, even in resistance situations in which what is current, interpersonal, and manifestly resistant or maladaptive may be analyzed. Students ought not be pushed, encouraged, or seduced to assume the rôle of patients in the public arena of the classroom. Learning about one's self and others at school must, by the very definition of the setting in which it occurs, be and be evaluated as an educative process.

AN EVALUATION OF TREATMENT METHODS IN ALCOHOLISM THERAPY

RUTH WILSON
Berkeley, California

CONSUMPTION of alcohol has been an almost universal phenomenon. There is scarcely a culture that has not used fermented beverages to some extent. However, while some individual deviation is always present, addiction as a social problem has been virtually unknown in many groups and civilizations.

In our own country the struggle of temperance crusaders has attested to the perennial existence of inebriety as a significant problem, as have legislative efforts culminating in the Volstead Act, which represented the employment of the time-worn "ordering and forbidding" technique of social control on a national scale. The false assumption of automatic solution was well illustrated by the reversion of the entire treatment "program" to police authorities and jails. Significantly, in 1920 the functions of the only inebriate hospital in New York were transferred to the department of correction.

Defenders of the 18th Amendment still contend that the "noble experiment" accomplished much, claiming that there is less excessive drinking now than in 1918. Quite apart from the lack of substantiated figures for that period, which renders the assertion incapable of proof, such arguments are beside the point in the face of the present situation. According to reliable estimates, inebriates now outnumber persons "suffering from cancer, tuberculosis, and infantile paralysis combined."[1]

There are encouraging signs that the government may recognize alcoholism as a valid and crucial public-health problem, and institute a program to match the need. Prior to World War II, however, not one state had a rational plan of cure, and even now, research is limited by a paltry $250,000 yearly grant. This, although estimates indicate that alco-

[1] See "Alcoholism: A Neglected Malady," by J. Hirsch. *New York Times Magazine*, April 10, 1949.

holism and its repercussions cost the nation $1,000,000,000 annually. One can, with Joseph Hirsch, sum up the situation in the indictment: "All patients, except the alcoholic—even the leper—are provided for."[1]

The nature of any approach to a problem necessarily depends upon the prevailing level of understanding of the character of that problem. Historically, alcoholism has been considered a moral problem, although isolated flashes of insight have marked the attitudes of a small minority of individuals as far back as the second century. Haggard[2] reports that Ulpian, the eminent Roman jurist, urged that inebriates be treated as "sick and diseased persons," but that it was not until 1804 that a representative of the medical profession, the Scotsman, Thomas Trotter, came out with a clear-cut statement anticipating the most modern opinion: "In medical language, I consider drunkenness, strictly speaking, to be a disease. . . . Perfect knowledge of remote causes which first induced propensity to liquors, whether from situations in life or peculiar temperament, is necessary for cure."

More than half a century was to pass, however, before these views were "at all appreciated and even now, though entirely accepted by students of inebriety, general medical regard has not wholly changed, and that of public opinion still less. . . . Study led to the search for cause, but . . . there is *still* no unitary theory of inebriety and the lack of such a theory is one of the greatest impediments to the solution."[3]

Here, then, is the crux of the whole matter; confusion in management, past and present, reflects the existence side by side of moralistic and scientific explanations for the same condition. As if this were not enough, the scientific explanations present a welter of largely unproven and monistic hypotheses from the fields of sociology, biology, biochemistry, medicine, and psychology. It is these that guide treatment procedure.

Still other "treatments" are almost entirely without theoretical foundation, being expedient defenses erected by a smug, indifferent, bewildered society against the annoying or

[1] *Ibid.*

[2] See *Alcohol Explored*, by H. W. Haggard and E. M. Jellinek. Garden City, N. Y.: Doubleday, Doran, and Company, 1942.

[3] *Ibid.*

threatening overt behaviors of the alcoholic, the end products of individual illness. Unfortunately, most public management is still of this variety. (Reference here is to incarceration and purely custodial care in municipal "drunk tanks," county farms and workhouses, state prisons, and mental hospitals.)

When we consider those efforts which are constructive and which are directed toward rehabilitating or curing alcoholics, we again encounter the dichotomy of alcoholism as conduct (sin) and as disease, although there is much overlapping of the two approaches. This is best seen when we examine the less recent methods of curing "the habit."

Cutten [1] relates that only two cures were mentioned at the meeting of the New York Academy of Medicine in 1901—hypnotism and religious conversion. Cutten himself claims 80 per cent "helped" by the former method, but agrees with Forel that it is not the "grand panacea." Religious conversion, however, was felt to be permanently effective because religious influence furnishes both "the prerequisite for any cure in arousing desire for help" and "justification by forgiveness of . . . sins. . . . The attitude toward life is changed." The New York Mission claimed 1,700 converted alcoholics, of whom roughly 63 per cent reportedly remained abstinent.

Seliger [2] states that "American psychiatry looked on the alcoholic problem as hopeless," but Bowers [3] could find that "good results follow psychological treatment" as practiced by Drs. Quackenbos, Sidis, Coriat, and others. By "powerful, persistent suggestion," they are reported to have "induced curative nausea—a revulsion of the soul against the very odor of alcohol." A Dr. Kane, of Tennessee, typified another psychological approach—that of attempting to break up the mental association between suffering and narcotic relief measures.

Biochemical and physiological notions abounded and there were "cures" to fit each. That many of these seem ludicrous from our more sophisticated viewpoint should not blind us to the fact that many earnest persons defended them

[1] See *The Psychology of Alcoholism*, by G. B. Cutten. London: W. Scott, 1914.

[2] See *Alcoholics Are Sick People*, by R. V. Seliger. Baltimore: Alcoholism Publications, 1945.

[3] See *Alcohol: Its Effect on Mind and Body*, by C. F. Bowers. New York: Grosset and Dunlap, 1916.

staunchly. For example, Dr. Christian, of Boston, "after exhaustive research, offers richest ice cream and an abundance of fine chocolates as best and surest cure."[1] Samuel Bailey, of Iowa, "has cured several hundred drunkards by feeding them apples," on the assumption that apples kill the desire for liquor. Again, "a large organization of Chicago women is campaigning against drink with apples."[2] What might be called the "radiant health" school of thought has perennially found widespread support. It was felt that a "wholesome" life would somehow insulate the individual against the morbid craving, or keep "nervousness" at a minimum.

The classical physiological treatment, the Keeley Cure, was originated by Dr. Leslie E. Keeley, who established his first institute at Dwight, Illinois, in 1880. The organization grew to national proportions, and it is reported that, by 1918, 400,000 persons had been "cured."[3] The theoretical basis for the treatment is that nerve cells, in adapting to the poison (alcohol or drugs), set up a demand for a repeated dose of the same substance. It is this that constitutes the phenomenon termed "craving." Therapy consists mainly in the subcutaneous injection of certain solutions, including double chloride of gold, at stated intervals over a period of from four to six weeks. This medication is alleged to restore the cells to their original unpoisoned state.

Contrary to common misconception, the cure does not immunize the patient from the harmful effects of alcohol, nor is a nausea reaction obtained. An interesting side result was the Keeley League (1891–1900), composed of an estimated 30,000 male "graduates." While there is no evidence that it functioned as a group-therapy device, it did yeoman's service in the cause of better understanding of alcoholism by carrying out its purpose of "spreading the doctrine that inebriety is a disease and is curable."[4]

To-day, the treatment picture is not quite so chaotic, nor are we so naïve as to place much faith in the efficacy of apples

[1] *Ibid.*

[2] *Ibid.*

[3] See "The Keeley Cure" in *Standard Encyclopedia of the Alcohol Problem.* Westerville, Ohio: American Issue Publishing Company (The Anti-Saloon League), 1925.

[4] *Ibid.*

or ice cream, although quackery still abounds. The trend is definitely toward a synthetic approach to therapy, and the realization is growing that alcoholics must be treated as individuals. For a long time "progress was impeded by two misconceptions: first, that all habitual excessive drinking is a disease; second, that it is the same disease."[1] If research has shown anything at all, it has "proved there are no uniform personality traits and no inebriate personality." The preponderance of evidence is that alcoholism is *not* a clinical entity.

Despite increased awareness of the desirability of merging therapeutic devices, many authorities still align themselves with specific methods. Although these emphases are not mutually exclusive, the situation warrants the discussion of modern treatment of alcoholism as comprising three general approaches. This paper will attempt to present the hypotheses behind each view and the claims of at least one of its representative exponents. Later, eclectic orientations will be considered.

The Conditioned-Reflex Aversion Treatment.—Probably the leading authority in this field is Dr. W. L. Voegtlin, medical director of the celebrated Shadel Sanitarium, of Seattle, Washington. It was he who originated the most satisfactory aversion method, based on a scientifically controlled application of the true conditioning technique as set forth by Pavlov. In this case, the sight, smell, or taste of alcoholic beverages constitutes the conditioned stimulus, while the unconditioned stimulus is the nauseant drug, emetine, injected hypodermically. The resulting psychological connection between the ingestion of drink and the nausea and vomiting that follow creates the aversion to the conditioned stimulus.

In his original description, Dr. Voegtlin reported "over 64 per cent of cures, based on a criterion of total abstention for four years or longer after treatment. These data were obtained from an unselected group of 685 patients."[2]

[1] See Haggard and Jellinek, *op. cit.*

[2] See "Conditioned Reflex Therapy of Alcoholic Addiction, III: An Evaluation of Present Results in the Light of Previous Experience With This Method," by W. L. Voegtlin, F. Lemere, and W. R. Broz. *Quarterly Journal of Studies on Alcohol*, Vol. 1, pp. 501–16, December, 1940.

In consideration of the recognized fact that the conditioned reflex tends to spontaneous extinction, but may be "maintained at its optimum strength indefinitely through a program known as reinforcement," Dr. Voegtlin inaugurated such a program. He felt that by a continuation of the treatments at intervals for at least a year (the period of highest relapse frequency), success would be greatly enhanced. One year after the new system was instituted, Dr. Voegtlin published a report[1] covering 285 patients, of whom 197 received one or more reinforcement treatments. He concluded: "It would appear reasonable to postulate total abstinence for at least one year in approximately 85 per cent of the patients who accept and coöperate with the reinforcement program."

Six years later (1947) Dr. Voegtlin reported a study covering the ten-year period of his experience and including 4,000 patients.[2] He found his former criterion inadequate because of further recidivism between the fourth and the tenth year, bringing the total abstinence figure down to 50 per cent. In the other cases, "supplementation with physical and social rehabilitation, formal psychotherapy, and other specialized procedures were necessary." Extramural groups were found to be of less value to the patients than their continued contact with the sanitarium.

In his latest evaluation (1948), Dr. Voegtlin states: "Reports from clinics with wide experience indicated [the method] has taken its place in the front ranks of methods.... An instinctive keen aversion remains for approximately several weeks; thereafter a lasting disinterestedness remains. This feeling of independence in regard to alcohol is the value of the treatment. It allows those who *want* to stop to do so. If they don't, *no* treatment could help them.... A more recent evaluation of 4,000 Seattle patients shows that a larger per

[1] See "Conditioned Reflex Therapy of Chronic Alcoholism, IV: A Preliminary Report on the Value of Reinforcement," by W. L. Voegtlin, F. Lemere, W. R. Broz, and P. O'Hollaren. *Quarterly Journal of Studies on Alcohol*, Vol. 2, pp. 505–11, December, 1941.

[2] See "Conditioned Reflex Therapy of Chronic Alcoholism: Ten Years' Experience with the Method," by W. L. Voegtlin. *Rocky Mountain Medical Journal*, Vol. 44, pp. 807–12, October, 1947.

cent (70) remained abstinent than from any other type of treatment."[1]

In one case study of 5,000 patients, it was found that potentially poor subjects for aversion therapy (given alone) were: "Youths under twenty-three years of age, chronic financial indigents, criminals, mental cases, and psychopaths."[2] According to Dr. Voegtlin, who recognizes alcoholism as a fundamental personality defect, "in individuals who possess sufficient residual psychic balance this is spontaneously repaired by the period of sobriety before the conditioned reflex becomes extinct."[3]

Dr. J. Thimann, Medical Director of Washingtonian Hospital, Boston, claims that after three years of follow-up, nearly 40 per cent of the patients were still abstinent. In this study the specific technique is not indicated. Dr. Thimann concludes that "success depends partly on selection."[4] If the addiction *per se* is the only difficulty, success will follow.

A new team, J. V. Edlin and associates, reports less success. In a preliminary study of 100 cases, 52 per cent were found to have remained sober for three months.[5] However, Voegtlin comments that Edlin's method allows the alcohol to remain too long in the stomach before conditioning is started.

Freedman states that Voegtlin, Lemere, and their associates have been distinguished in the conditioned-reflex field by the "unique precision of their application of Pavlov's findings . . . their success rates are well above those reported by other investigators using different treatment methods."[6] Thus aversion therapy is not confined to the process discussed above. Two other treatment procedures of this type warrant mention here.

[1] See "The Conditioned Reflex Treatment of Chronic Alcoholism," by W. L. Voegtlin. *Hygeia*, Vol. 26, pp. 628–29, September, 1948.

[2] *Ibid.*

[3] Quoted by B. Freedman in "Conditioned Reflex and Psychodynamic Equivalents in Alcoholic Addiction: An Illustration of Psychoanalytic Neurology With Rudimentary Equations," *Quarterly Journal of Studies on Alcohol*, Vol. 9, pp. 53–71, June, 1948.

[4] See "Half of Alcoholics Helped," by J. Thimann. *Science News Letter*, May 5, 1945.

[5] Quoted by Freedman, *op. cit.*

[6] *Ibid.*

The first is the so-called "McBride Treatment," which attempts to establish aversion to liquors through increasing doses of strychnine and atropine. This technique is not recommended by the American Medical Association.[1]

The second method involves medication with tetraethylthiuram disulfide (antabus) as an adjunct to psychotherapy with coöperative patients. As practiced in Denmark, apparently, the patient is given the drug to take at home in conjunction with alcoholic beverages and is instructed to report progress by telephone.[2] Present evaluation of the merits of the specific is difficult, because of its combination with psychotherapy. In as much as unexpected results, such as heart attack, convulsions,[3] peripheral vascular collapse, and respiratory failure[4] have been reported, it would seem that the danger involved is great, especially for home treatment.

Timely research on the whole subject of the aversion field is under way at the Yale Plan Clinic. Special emphasis will be given to studying two possibilities: (1) application of the treatment to patients with low I.Q.'s who cannot benefit from psychotherapy; and (2) a simplification of the technique to allow for treatment on an ambulatory basis. The significance of the latter objective may not be sufficiently appreciated by those who are unaware of the selective factor incident to the high cost of such treatment. At present, far too many institutions apparently base their charges on the principle of what the traffic will bear. This means that inestimable numbers of potential beneficiaries are excluded because they are unable to meet the costs of treatment.

The final chapter in the saga of conditioned-reflex therapy has yet to be written. There are several points to be considered when one attempts to evaluate its record. For one

[1] See "Chronic Alcoholism." *Journal of the American Medical Association*, Vol. 136, p. 70, January 3, 1948.

[2] See "Treatment of Alcoholism With a Sensitizing Drug," by O. Martensen-Larsen. *Lancet*, Vol. 255, pp. 1004–05, December 25, 1948.

[3] See "Allvarlig Komplication vid Antabus," by L. Linden. *Svenska Läkartidn*, Vol. 45, pp. 2469–70, 1948.

[4] See "Preliminary Report on Clinical Trials of Antebuse," by R. G. Bell and H. W. Smith. *Canadian Medical Association Journal*, Vol. 60, pp. 286–88, March, 1949.

thing, the technique has not had "sufficient widespread *scientific* application to determine its value and place in the treatment picture.[1] Voegtlin holds that the utmost precision is necessary in the pharmacological procedure; that "much of the failure of the method may be laid at the door of the pseudo-scientific persons who have availed themselves of the 'formula' and apply a standard treatment to all patients, and where facilities are lacking."[2] This alone could account for the failure of many so-called sanitaria, which can most aptly be described as mass-production centers. And here we are considering the physiological aspect only. Lemere[3] stresses the importance of such psychological elements as the cameraderie of the patients and their informal discussion of their cases, "which is the best type of group therapy"; the warning supplied by the ignominious arrival of relapsed and desperate cases; the power of the suggestive effect of the conditioning seance *per se,* which should be "dramatic and impressive"; and the meaningful aspects of the follow-up.

In general, criticism directed at the method centers around etiological considerations. It is felt that most alcoholic addiction is symptomatic of underlying emotional maladjustment and that establishing an aversion to liquor merely treats the symptom, leaving the fundamental disorder untouched. This is really not a rejection of the technique, but a revolt against its use uncombined with psychotherapy. This attitude is uncompromisingly expressed by Carver,[4] who states that "suppression of the symptom while the cause is not removed may cause resort to other means of relief."

Although this prognostication may be valid, it is not upheld by the experience of the Shadel Sanitarium. Lemere,[5] the consulting psychiatrist, says: "It is surprising how few show evidence of major neuroses after quitting." Another argu-

[1] See Voegtlin, Lemere, and Broz, *op. cit.*

[2] See Voegtlin, Lemere, Broz, and O'Hollaren, *op. cit.*

[3] See "Psychological Factors in the Conditioned Reflex Treatment of Alcoholism," by F. Lemere. *Quarterly Journal of Studies on Alcohol,* Vol. 8, pp. 261–64. September, 1947.

[4] See "How to Break Off Alcohol," by A. E. Carver, a letter in the *British Medical Journal,* April 1, 1944, p. 468.

[5] See Lemere, *op. cit.*

ment is advanced by Hoch,[1] who reminds us that "alcoholics have been treated for years by competent psychoanalysts, with much improvement in personality disorders, but failure to achieve permanent abstinence." He explains this seeming paradox by assuming that "while the underlying neurosis was instrumental in the development of compulsive drinking, from its establishment the drinking becomes an automatic disease independent of underlying cause. . . Until the introduction of the conditioned reflex treatment, therapy of alcoholic addiction was one of the saddest chapters of psychiatry."

Freedman[2] feels that while "research may discover some type of pharmacodynamic reconditioning," at present psychodynamic (psychoanalytical) therapy is the only "radical one." He, too, takes an anti-particularistic position, suggesting the use of the conditioned reflex to "attack the conditioned external stimuli" and psychoanalysis for the "liquidation of the internal reinforcement."

While total treatment at the Shadel Sanitarium eventually included a mild type of psychotherapy oriented toward "reassurance, education, and persuasion,"[3] at the Raleigh Hills Sanitarium in Portland, Oregon, (successor to the Shadel Sanitarium) the approach is more strictly medical. The single psychiatric interview is devoted to case-history taking and frankly oriented toward research. Most alcoholism is definitely considered to be a physiological problem, aggravated, perhaps, by situational factors. Regarding the patients as in any way "mental cases" is strongly resented; in fact, this attitude is held to be one reason for the comparative failure of psychiatry in this field. (If this thesis were accepted, it would be difficult to imagine conditioned-reflex and traditional psychiatric approaches in mutually enhancing rôles.)

The sanitarium has contributed no available statistical report, but it is thought that success rates would compare favorably with the Shadel figures. In this connection it is

[1] Quoted by J. Thimann in "Constructive Teamwork in Treatment of Alcohol." *Quarterly Journal of Studies on Alcohol*, Vol. 8, pp. 569–79, March, 1948.

[2] See Freedman, *op. cit.*

[3] See Lemere, *op. cit.*

significant that the staff complains—with justice, the present author believes—that their tables of "cure" frequencies list only those cases that have never relapsed, whereas the estimates of champions both of psychiatry and of Alcoholics Anonymous reflect no such conservatism.

It seems to the present author that this brings up a crucial point which might well account for much of the confusion in the whole field of treatment and, indirectly, in the etiological field as well. While the ultimate success of treatment obviously awaits fuller knowledge of what alcoholism *is*, treatment *per se* is one type of experimental research, and until there is consensus on such fundamental factors as criteria, so that findings may be made comparable, conclusions and interpretations will be meaningless. The solution of this problem could well be one goal of the present Yale Clinic Plan Research Project, if it is not already.

In the area covered by physiological techniques, three additional efforts deserve mention. The administration of subshock doses of insulin is believed by some to lead to effective cure. Pullar-Strecker[1] recommends insulin only when combined with apomorphine (a nauseant drug) as supplemental to psychotherapy. Because of "its effects upon personality and reorientation, it is superior to every known physical agent." Malamud,[2] however, reports two fatalities, indicating that there are wide differences in individual reaction to the drug. Perhaps it would be wiser if psychiatry would confine itself to less drastic methods of promoting rapport and insight.

Another therapeutic device used in some circles is the spinal puncture. Here, again, conflicting opinion reigns. Voegtlin and Lemere[3] state: "Spinal drainage and other efforts to reduce cerebral edema have produced inconclusive and inconsistent results."

[1] See "Apomorphine Plus Insulin for Alcoholic Addiction," by H. Pullar-Strecker. *Medical Press*, Vol. 212, pp. 11–13, July 5, 1944.

[2] See "Fatalities From Treatment With Subshock Doses of Insulin," by W. Malamud. *American Journal of Psychiatry*, Vol. 105, pp. 373–76, November, 1948.

[3] See "Treatment of Alcohol Addiction; Review of Literature," by W. L. Voegtlin and F. Lemere. *Quarterly Journal of Studies on Alcohol*, Vol. 2, pp. 717–803, March, 1942.

In response to a "deluge of inquiries" concerning the recently publicized "Seven-Day Cure" (based on the immunization principle) the *Journal of the American Medical Association*[1] comments pithily that the idea of treating alcoholism with alcohol is "no more sensible than treating diabetes with sugar." In the same statement we find the general summary of skeptical official medical opinion:

"No cures so far which have stirred the alcoholic world during the past 30 years seem of much permanent effect, [including] drug treatment with strychnine and curare, emetine and apomorphine conditioned-reflex therapy, electric shock, hypnosis, and treatment with amphetamine ('benzedrine') sulfate."

Psychotherapy.—It is only when we discuss the psychiatric management of alcoholism that we fully realize how dependent the whole treatment approach is upon etiological and nosological conceptions. As a result of the maze of divergent and often contradictory psychological theories purporting to explain the origin, development, and nature of alcoholism, we find a corresponding diversity of treatment procedures. These run the full gamut subsumed under the term psychotherapy, used in a broad sense.

In general, the methodological technique varies according to how seriously the condition is viewed—whether as reflecting a deep or a superficial maladjustment of the personality. Within this framework all shades of opinion abound. Moreover, the question arises: Should alcoholism be regarded as syndrome, as symptom, or as comprising a whole series of categorical types? Again, there is the view that none of these approaches is compatible with the recent findings of differential psychology. The current confusion in thought on the subject is well illustrated by the following excerpts from the writings of qualified authorities:

> Karl Menninger: "Alcoholism is more serious than any neurosis . . . I would rather have a young relative of mine develop schizophrenia."[2]

[1] See "Seven Day Cure for Chronic Alcoholism." *Journal of the American Medical Association*, Vol. 135, pp. 577–78, November 1, 1946.

[2] Quoted by R. P. Knight in "The Psychoanalytic Treatment in a Sanitarium of Chronic Addiction to Alcohol." *Journal of the American Medical Association*, Vol. 111, pp. 1443–48, October 15, 1938.

G. N. Thompson: "Treatment of most alcoholics is treatment of the underlying psychoneurosis."[1]

E. M. Jellinek: "There are true changes of attitudes and conduct due to the social consequences and physical stresses of alcoholism. Many . . . *appear* to be clinical neuroses. That in a large proportion of alcoholics there is only this neurotoid [manifestation], or that it prevails over early conflicts is indicated by the simplicity of the means to relieve and cure."[2]

Helen Marshall: "The characteristic personality changes can all be interpreted as the result of the alcoholism, not etiological factors in its development."[3]

E. M. Jellinek: "The first step is to keep the types distinct. . . . There is confusion from failure to differentiate between addiction and symptomatic inebriety. It has been noted that . . . some 40 per cent are psychotics, psychopaths, or feebleminded. One must discriminate carefully, to know what to treat."[4]

M. Floch: "The chief disadvantage of classifications is the superficiality and resultant heterogeneity within the classes."[5]

C. H. Durfee: "There is no formula. Treatment is according to individual reaction, and is often dictated by the moment or the situation."[6]

R. V. Seliger: "Society has erred by discussing alcoholism instead of the individual alcoholic."[7]

Psychotherapeutic treatment of alcoholism divides itself into two classes, generally speaking: traditional psychoanalysis, and a nameless category which includes a medley of less intensive approaches to personality adjustment.

One of the foremost sanitaria specializing in psychoanalysis is the Menninger Clinic at Topeka, Kansas. There the program, outlined to cover from eighteen months to four years, depending on the severity of the case, typified the methods practiced by conventional psychiatry on a non-ambulatory basis. Total treatment included physical build-up, a strict

[1] See "A Psychiatric Formulation of Alcoholism," by G. N. Thompson. *Quarterly Journal of Studies on Alcohol*, Vol. 7. pp. 346–55, December, 1946.

[2] "Phases in the Drinking History of Alcoholics," by E. M. Jellinek. *Quarterly Journal of Studies on Alcohol*, Vol. 7, pp. 1–88, June, 1946.

[3] "A Study of the Personality of Alcoholics," by Helen Marshall. *American Psychologist*, Vol. 2, p. 289, August, 1947.

[4] See *Effects of Alcohol on the Individual; Alcohol Addictions and Chronic Alcoholism*, by E. M. Jellinek. New Haven: Yale University Press, 1942.

[5] See "Imprisoned Abnormal Drinkers: Application of the Bowman-Jellinek Classification Schedule to an Institutional Sample," by M. Floch. *Quarterly Journal of Studies on Alcohol*, Vol. 7, pp. 518–66, March, 1947; Vol. 8, pp. 61–120, June, 1947.

[6] See "Some Practical Observations of the Treatment of Problem Drinkers," by C. H. Durfee. *Quarterly Journal of Studies on Alcohol*. Vol. 7, pp. 228–39, September, 1946.

[7] See Seliger, *op. cit.*

regimen, and "minute planning of doctor and nurse attitudes."[1] In fact the only way in which treatment of alcoholics differed from that of other patients was in the way the transference was "intentionally developed and used."

Dr. R. P. Knight, of the Menninger staff, has published a study[2] of 20 unselected male cases seen by him over a period of five years. Of these, 19 cases came under pressure or coercion, "often by deception," and all were subjected to complete curtailment of freedom for varying periods of time.

In presenting his results, Dr. Knight divides his population into two groups, composed of eleven cases who had undergone psychoanalysis and nine who had not. Of the first group, two were "still in analysis" and nine had stopped treatment. Four of these nine had been removed by relatives, and of these, one was "slightly improved," one was a "bad recidivist," and two were "moderately improved after some months"; of the other five, one was "improved," three were "moderately improved," and one was "much improved." Of the second group, two patients were "unchanged"; two had become recidivists "after a few months"; four were "improved, but by now are probably recidivists"; and one, an out-patient, was considered cured, but he had "stopped drinking on his own two years previously."

In connection with this study, one cannot but recall Hoch's characterization of the therapy of alcoholism as "one of the saddest chapters of psychiatry."[3]

Dr. Knight concludes that treatment of alcoholism presents enormous difficulties. He feels that in most cases he is unable to carry out the treatment plan long enough to effect permanent changes. Fortunately Dr. Knight's explanation is not shared by all psychoanalysts, for we find others of the same discipline advocating a type of short-term therapy.

This approach is exemplified by the staff of the Chicago Institute for Psychoanalysis and is set forth by Dr. Alexander and French in their book, *Psychoanalytic Therapy: Principles and Application.*[4] To quote from a review of the book in

[1] See Knight, *op. cit.*

[2] *Ibid.*

[3] Quoted by J. Thimann in "Constructive Teamwork in Treatment of Alcoholism," *loc. cit.*

[4] New York: The Ronald Press, 1946.

Quarterly Journal of Studies on Alcohol,[1] their thesis is that "therapeutic success and duration and intensity are not necessarily correlated." They find it possible to make two radical changes in psychoanalytic techniques. The first involves subordinating "intellectual insight, abreaction, and recollection of the past . . . to the creation of a new emotional experience in which the 'morbid effects' of early emotional impacts tend to become dissolved." The second is the possibility of "dispensing at times with the transference neurosis and being satisfied with the elements of plain, good rapport." The reviewer adds: "The aloofness of the analyst has often been mentioned as a drawback in analytic therapy of alcoholic addiction."

Another simplification in procedure is suggested by Woolley,[2] who recommends projective techniques as "valuable shortcuts to an understanding of the underlying problem of the patient."

Other forms of interview and so-called "revamped" psychiatry are more popular and, again, such questions as the elements to be stressed, the relative intensity and duration of treatment, the necessity of hospitalization, the need of restraint, and the type of therapist-patient relationship are dictated by the etiological and nosological conceptions of the individual doctor. The general aim of all these methods is perhaps most succinctly expressed by Carroll[3] as the patient's "attainment of emotional security and a mature acceptance of life." Acceptance of life, here, includes accepting the subjective fact that he cannot take alcohol in any form as long as he lives.

Theoretically, it might be expected that some form of psychiatry could achieve its ends with reasonable frequency. Thimann asks: "What are the results of the purely psychiatric approach, on the premise that addiction is symptomatic of an underlying personality disorder and that eliminating the disorder will cause the symptom to disappear?"[4]

[1] Vol. 8, pp. 134–35, June, 1947.

[2] See "New Approaches to Understanding the Alcoholic," by L. F. Woolley. *Alcohol Hygiene,* Vol. 1, pp. 3–7, January 1, 1945.

[3] See *What Price Alcohol?* by R. S. Carroll. New York: The Macmillan Company, 1941.

[4] See Thimann, "Constructive Teamwork in Treatment of Alcoholics," *loc. cit.*

There is a dearth of studies, but the impression gleaned from diverse sources is that psychiatry, unaided, has to all intents and purposes failed. This impression has been verbalized by Tiebout, a leading psychiatrist in the alcoholic field: "Psychotherapy, with an occasional notable exception, has proved disappointing. A ten to fifteen per cent recovery rate is average."[1]

Both psychiatry and its critics have advanced explanations to account for this poor record. Menninger's thesis is that "the difficult and characteristic thing about the psychiatric picture is that they [alcoholics] have fluctuating periods of anxiety between which they feel relatively comfortable. When they have acute anxiety, they drink, and hence are inaccessible to treatment. When they cease to have anxiety, they don't want treatment."[2]

Most authorities agree that the alcoholic vacillates between phases of feeling alternately discouraged and overconfident about his condition, and that he suits his actions to the emotional tone of the moment. But Dr. Menninger's attitude could be viewed as shifting the blame entirely onto the patient's shoulders; after all, both the conditioned-reflex school and Alcoholics Anonymous deal with the same unpredictable individual, and with far more satisfactory results.

Another suggestion comes from Buhler and Lefever, who see alcoholism as "presenting a peculiar psychotherapeutic problem. Approaches which are successful with psychoneuroses are not with alcoholics, and vice versa."[3] They continue: "Acute tension is [the alcoholic's] problem. Escape to alcohol is not a parallel to psychoneurotic symptoms that are reactions to deep-level conflicts. It is escape from acute pressure, whether aggravated by deep-level conflicts or not." Here we encounter the familiar etiological snag. In short, to what extent has psychiatry been confusing causes with effects?

[1] Quoted by J. Thimann in "Constructive Teamwork in Treatment of Alcoholism," *loc. cit.*

[2] Quoted by R. P. Knight, *op. cit.*

[3] See "A Rorschach Study on the Psychological Characteristics of Alcoholics," by C. Buhler and D. W. Lefever. *Quarterly Journal of Studies on Alcohol*, Vol. 8, pp. 197–260, September, 1947.

Another relevant issue is the question of the personality and attitude of the therapist. Williams[1] contends that the physician "must enter into their [the patients'] feelings." Davis[2] introduces what seems to the present author a novel and significant idea: there must be "understanding and sympathy and kinship. The examiner must not be unstable and high-strung, but must not be too stable. There are no results if he is at the opposite pole from the patient." Here is an intimation of what we shall discover to be one of the outstanding elements in the success of Alcoholics Anonymous, "consciousness of kind."

Rogers[3] discusses several unsatisfactory psychotherapeutic methods which have been freely employed in dealing with all types of psychiatric patients: "Orders and threats are not techniques which basically alter human behavior. . . . Exhortation and pledges and promises are not successful in bringing about a real change. . . . Advice and persuasion . . . might be called intervention. . . . Such an approach has two major weaknesses. The individual who has a good deal of independence necessarily rejects such suggestions in order to retain his own integrity. On the other hand, the person who already has a tendency to be dependent and to allow others to make his decisions is driven deeper into his dependency. Intellectualized interpretation . . . formed a significant part of classical psychoanalysis, [but] to trace symptoms back to a childhood cause, or to explain the way in which symptoms are easing intolerable life situations, may have no effect, or an adverse effect, on therapy unless the client can accept these interpretations."

Tiebout[4] finds that success depends largely on gaining the *coöperation* of the alcoholic patient and that traditional efforts in that direction have not been fruitful. "The Good Samaritan is so busy rescuing that he fails to see that he is injecting

[1] See "Management of Chronic Alcoholism," by E. Y. Williams. *Psychiatric Quarterly*, Vol. 21, pp. 190–98, April, 1947.

[2] See "Recreational Therapy for the Chronic Alcoholic," by J. E. Davis. *Psychiatric Quarterly*, Vol. 19, pp. 450–64, July, 1945.

[3] See *Counseling and Psychotherapy*, by C. R. Rogers. Boston: Houghton Mifflin Company, 1942.

[4] See "The Problem of Gaining Coöperation From the Alcoholic Patient," by H. M. Tiebout. *Quarterly Journal of Studies on Alcohol*, Vol. 8, pp. 47–54, June, 1942.

himself into the life of another, who can rightfully object. . . . So the primary focus is the patient. Treatment cannot be hurried and must wait on events."

Dr. Tiebout's thesis is that the alcoholic goes through three stages. In the beginning, he flatly refuses any sort of treatment, especially hospitalization, except as "reconditioning in order to drink again." Later, as his concern grows, he "listens to advice and disregards it. . . . He is experimenting, but half-heartedly." Finally he arrives at the stage of complete surrender. Throughout this painful procedure the physician, mindful of his convictions, allows the patient to grow at his own pace. "To be dogmatic arouses hostility. . . . Don't argue with him, but keep the door open. . . . Alcoholics have a peculiar unconscious sense of invulnerability; although they feel threatened, they just 'can't be licked.' There is no known way to weaken this, but it gradually diminishes."

It seems to the author that Dr. Tiebout, in emphasizing the necessity of treating the alcoholic in a permissive atmosphere, brings out a crucial point too often neglected by the majority of therapists. He appears to possess unusual insight as well as the courage to act upon the conclusion inescapably resulting from his empirical observations. It might well be that much psychotherapeutic failure has been due to the impatience of the therapist; he mistakes the ambivalence symptomatic of the second stage with incorrigibility, and forthwith washes his hands of the case. In Dr. Tiebout's phraseology, one would say that he closes the door.

If it were possible to obtain figures on the success of the various approaches within the general field of psychiatric cure—for Dr. Tiebout's own sanitarium, for example—these figures might furnish the basis needed for a more accurate evaluation of the merits of psychotherapy of alcoholism.

At the same time there is the possibility that the basic etiological assumptions of current psychology subvert its efforts at their source. This view is held by many experienced workers, including Hirsch,[1] who holds that the usually accepted psychological reasons for alcoholism "do not explain why 56 million social drinkers with similar backgrounds, prob-

[1] See Hirsch, *op. cit.*

lems, and anxieties can control their drinking indefinitely." Thompson[1] has this to say: "Regardless of the type of treatment, *one fact emerges:* until the alcoholic finds that life *without* alcohol is more satisfying than life *with* alcohol, he will drink to intoxication. He must become constitutionally able to use the stimuli of the environment adequately, [but] the environment must offer stimuli adequate to his stabilizing." He concludes: "The alcoholic problem belongs in Social Psychiatry."

Alcoholics Anonymous.—A.A., now in its fifteenth year, boasting an estimated membership of 80,000 and "winning 1,000 new members a month,"[2] began without fanfare in Akron, Ohio. The founders were several ex-alcoholics who "discovered one another through a kindred experience,"[3] evolved a Program of Recovery, and made an avocation of taking their message to other alcoholics. The experience referred to was in the nature of a profound religious inspiration. Abandoned by medicine and psychiatry, facing "madness or death," these individuals in desperation performed an act of faith; they turned over their lives and wills to God, and it "worked."

The spread of the movement and its accomplishments are too well known to need repetition here; by now there is scarcely an informed person who has not heard or read of "A.A." But it is not in structure and reputation alone that A.A. has developed. In performing its function, the group has been forced to adopt a more or less formal set of concepts relating to alcoholism and the rôle of the program in therapy.

Lost in an etiological maze, the early members abandoned the search for an original cause and confined themselves to the application of their principles. Empirically, they had observed several facts which they synthesized into a working hypothesis:

1. That alcoholism involves a physical component. This they think of as an "allergy" to alcohol, supporting their contention by case after case in which, in the face of satisfying, favorable situations and circumstances, alcoholics, after a

[1] See Thompson, *op. cit.*
[2] See "Problem Drinkers." *The Survey*, Vol. 83, pp. 80–1, June, 1947.
[3] See *Alcoholics Anonymous.* New York: Works Publishing Company, 1947.

single drink, develop a craving that becomes paramount to every other interest. "These men were not drinking to escape."[1]

2. That alcoholism involves a mental (emotional) element. This is the factor that explains the taking of the first drink in the face of certain disaster.

3. That intellectual insight is useless.

4. That only a new life based on spiritual principles can save an alcoholic. This personality change is achieved through adherence to the "Twelve Steps" which constitute the "Program."

A.A. has not changed its basic tenets, but has responded to a felt need to clarify its position. In the process, the members have picked up a good deal of psychological sophistication, accepting the diagnosis of egocentricity, perfectionism, alcoholism as escape mechanism symptomatic of personality maladjustment, and so on.

According to A.A., the main difference between medicine and religion in treating the alcoholic is that the former sets self-dependence as the goal, while the latter insists that faith in *self* is not enough. In defining its own status, A.A. states: "A.A. is a synthetic concept drawing upon the resources of medicine, psychiatry, religion, and our own experience. We have merely streamlined old principles into such forms that the alcoholic will accept them. And then we have created a society of his own kind where he can enthusiastically put these very principles to work on himself and other sufferers. These are our major contributions."[2]

In regard to the "Program" proper, "Bill" Wilson, a founder, interprets the Twelve Steps as essentially:

"a. Admission of alcoholism.
"b. Personal analysis and catharsis.
"c. Adjustment of personal relations.
"d. Dependence upon some Higher Power.
"e. Working with other alcoholics."[3]

When we attempt to check the record, we again encounter confusion. The general impression, based on the claims of

[1] See "Problem Drinkers," *loc. cit.*
[2] *Ibid.*
[3] *Ibid.*

the organization, is that about 75 per cent are cured. However, Sharp[1] states: "I would estimate 20 per cent more or less permanently helped." He goes on to call attention to a point that the present author brought out earlier: "Any numerical claims or estimates of therapeutic results with alcoholics are suspect." I mentioned the lack of criteria; now Sharp blames both failure to differentiate categories and inadequate follow-up.

By this time another danger may have suggested itself—namely, that in many successful cases there is no way of being sure which specific deserves the credit. When, as is often the case, alcoholics combine A.A. with psychiatry or conditioned-reflex therapy or a combination of both, the possibilities for confusion stagger the imagination.

Whatever the figures, there is no doubt that A.A. deserves a prominent place in modern alcoholism therapy. As Farber[2] puts it: "Of all the methods devised by state, clergy, or the medical profession for curing alcoholism, none has ever been so popular or highly publicized. . . . Where other methods tend to say, 'Now you are cured; go back to your life,' this voluntary association is unique in offering not a 'cure' so much as a 'life.' "

Experts have long attempted to discover what it is that constitutes A.A.'s power. Bird[3] echoes the mystification of the more modest authorities: "A.A. seems to help more than the others, no one knows why. After five years of studying A.A., I *think* it does something about the fear in the man's heart." Farber,[4] a friendly critic, frankly admits defeat: "Even with its preposterous rag-bag of theory, A.A. has something of communicable value to offer the social sciences, but so far no psychiatrist has been enough of a sociologist and no sociologist has been enough of a psychiatrist to discover what it is."

[1] See "The Treatment of Alcoholism," by L. I. Sharp. *Hygeia*, Vol. 26, pp. 396–97, 441–42, June, 1948.

[2] See "Blueplate Gospel," by L. H. Farber. *New Republic*, Vol. 112, p. 716, May 21, 1945.

[3] See "One Aspect of Causation in Alcohol," by B. Bird. *Quarterly Journal of Studies on Alcohol*, Vol. 9, pp. 534–43, March, 1949.

[4] See Farber, *op. cit.*

The attitude of the enlightened contingent of the medical profession is one of heartfelt appreciation. Rotman[1] states: "A.A. needs a close coöperation with the medical profession, but the medical profession needs close coöperation with A.A. even more. The physician should see the disease in its entirety—as a social disease."

Whatever division of opinion exists centers largely around the religious issue. Because of the earlier stress on cure through religious conversion and the constant talk about the Higher Power, there are those who hold that the essence of A.A. is a return to God. Tiebout[2] expresses this section of opinion when he says: "While fully cognizant of the fellowship values of the group . . . I regard them as accessory to the central therapeutic force, religion." Thus it is not too surprising that A.A. has acquired the reputation in some quarters of being some sort of revivalist religion.

A.A.'s reply to the allegation is a vigorous denial. Spokesmen point out that only a minority have ever undergone a sudden conversion experience. What actually happens is that the member gradually experiences a "personality change at such a rate and of such dimensions that he cannot fully account for it on the basis of self-realization and self-discipline. Hence he concludes that 'a Power greater than himself' must indeed have been at work. This is what most A.A.'s are trying to say when they talk about a spiritual experience."[3]

The attitude of the rank and file toward the "God angle," as they call it, is that they were helpless in the face of their drinking and that they found it relatively easy to accept some greater power since every alcoholic has already met one—John Barleycorn. However, they greatly prefer the term "spiritual" to "religious" in describing their program. It is not difficult to find the reason for the euphemism; in the past, religion has failed dismally in its attempts at regeneration. If there is one thing in the whole tangle of alcoholism

[1] See "Alcoholism, a Social Disease," by D. B. Rotman. *Journal of the American Medical Association*, Vol. 127, pp. 564–67, March 10, 1945.

[2] See "Therapeutic Mechanisms of Alcoholics Anonymous," by Harry M. Tiebout. *American Journal of Psychiatry*, Vol. 100, pp. 402–5, January, 1944.

[3] See "Problem Drinkers," *loc. cit.*

of which we can be sure, it is that the alcoholic is resistant to any form of "preaching," often, quite literally, to the death.

On the other hand, there are those who hold that the explanation of A.A.'s success lies in the field of psychiatry or sociopsychology, and that the *modus operandi* leading to growth of personality is group interaction. The membership becomes the socializing primary group for the alcoholic who, probably more than any other individual, suffers from social isolation.

The extreme of this opinion is expressed by Farber,[1] who suggests that "what really goes on bears little relation to the blueplate values offered as explanation and inducement. . . . There is perhaps a fortunate discrepancy between the 'religious' flavor of the pamphlets and the actual beliefs and practices. The 'Greater Power' so earnestly invoked . . . has little to do with the prevailing faith, a strong group loyalty activating the members and supplying them with another missing factor in their lives." He adds: "Each member is at once both patient and physician; only from a fellow alcoholic can they receive that acceptance without condescension which society has withheld."

Wender [2] speaks of "patient-to-patient transference, occurring in group therapy, [which relationship] in time takes an outward course, embracing a wider area of interests and activities." In this sense the "spirituality" of the movement might be construed as a socio-ethical philosophy resulting from the diminution of alcoholic egocentricity characterized by Tiebout [3] as "defiant individuality" and "grandiosity."

A fairly typical psychoanalytic explanation is offered by Freedman,[4] who sees the therapeutic mechanism of A.A. as "the incorporation of the coöperative group replacing the oral incorporation of alcohol," which, we are told, has functioned as a "socially authoritative antagonist to the hypercritical portion of the super-ego."

[1] See Farber, *op. cit.*

[2] See "Dynamics of Group Psychotherapy and Its Application," by L. Wender. *Journal of Nervous and Mental Disease*, Vol. 84, pp. 54–60, July, 1936.

[3] Quoting L. S. Sillman in "Therapeutic Mechanism of Alcoholics Anonymous," *loc. cit.*

[4] See Freedman, *op. cit.*

Tiebout,[1] who holds the act of surrender (of resistance) as the essential preliminary to successful therapy, finds it "a striking parallel to conversion." In psychological terms, then, the so-called conversion experience of certain A.A.'s could be explained as a flash of insight not necessarily involving any supernatural connotation. It is significant that those few who swear to metaphysical manifestations, such as "the thundering voice of God," were in a highly nervous, suggestible state, if not actually bordering on delirium tremens, at the time.

Avoiding particularism and the assigning of weighted values, let us attempt to discover those specific aspects of A.A. which are unique—or were before they were borrowed by other treatment approaches—and which appear to be of significance to therapy.

First of all, there is the fact that the therapist is a kindred spirit, a "fellow rummy," as A.A. would say. The advantage of this "training" in establishing rapport is incalculable. In the crucial initial contact, the alcoholic, for the first time in his life, is made to feel that the individual approaching him *really* understands and accepts him and his problem. As one member put it: "You're more prone to listen to those who are like yourself and not to those on the outside." There is a further merit inherent in this consciousness of kind; it makes possible instantaneous identification, which inspires in the sufferer what he so sorely needs and has not been able to discover elsewhere—faith. One might say that here, in the person of the recovered alcoholic, is a living proof that his is not necessarily a lost cause.

If this is not enough, at his first meeting he encounters a whole group of cordial, apparently well-adjusted people who are obviously finding a dry life enjoyable. "I wanted what they had," remarked one member. "I was no longer alone," added another. "There is no ridicule," concluded a third. Regarding A.A.'s permissiveness, a spokesman[2] states: "We care not whether his case is severe or light, whether his

[1] See "The Act of Surrender in the Therapeutic Process With Special Reference to Alcoholism," by H. M. Tiebout. *Quarterly Journal of Studies on Alcohol*, Vol. 10, pp. 48–58, June, 1949.

[2] See *A.A. Tradition*. New York: Works Publishing Company, 1947.

morals are good or bad, whether he has complications or not. Our door stands wide open. . . . Though he may be thrown out of a club, nobody thinks of throwing him out of A.A."

Whatever part of the personality change may be attributed to the intervention of the "Higher Power," the therapeutic value of the group is denied by no one. Autobiographically, an early member[1] wrote: "Talking things over with them, great floods of enlightenment showed me myself as I really was and I was like them. . . . Suddenly I could accept myself, faults and all, as I was—for weren't we all like that? And, accepting, I felt a new inner comfort, and the willingness and strength to do something about the traits I couldn't live with."

Bird[2] suggests that merely to get a man to stop drinking is "as cruel and useless as turning one's back on a cripple after taking his crutches." Many psychiatrists agree that the void left by the removal of alcohol must be satisfactorily filled and suggest substituting a hobby. A.A. supplies this requirement in "twelfth-step work" (helping other alcoholics), which, besides providing "social insurance," is a made-to-order avocation. One member writer,[3] however, presents an interesting hypothesis: "In A.A. the hobby is *oneself*—building and perfecting one's personality and life toward the concept of what one would want to be." Whatever it is, the hobby is an engrossing and adequate one. At least one finds no evidence of aching voids in the lives of successful members of A.A.

One last unusual psychological device of A.A. deserves mention—the "24-hour program." True to its empirically gained understanding, A.A. has adopted a policy of "no coercion, no promises, no pledges." However, it does remind the drinker that *any one,* to save himself, can stay dry for *24 hours.* This gives the novice and many an older member something to keep going on from day to day without which he would probably not survive. Indeed, it is a question whether the majority would embark on the program at all were it not for this sheer stroke of genius. Heretofore, the

[1] See *Alcoholics Anonymous,* previously cited.
[2] See Bird, *op. cit.*
[3] See "A.A." *Hygiea,* Vol. 26, pp. 496–97, July, 1948.

alcoholic had been told, gently or bluntly, that he could never drink *as long as he lived.* This has always been the principal stumblingblock in alcoholic therapy. As one member puts it: "Others present a lifelong dry prospect—a horrible thought! A.A. avoids this." Again:[1] "Alcohol was my prop, and I didn't see how I could live without it. When my doctor told me I should never drink again, I *couldn't afford* to believe him." Carroll[2] sees this inability of the alcoholic emotionally to accept lifelong sobriety as "the crux of the deficiency with many drinkers."

The psychological repercussion of adopting the 24-hour philosophy are far-reaching and have proved an invaluable aid to permanent recovery. The above-quoted anonymous author[3] describes them as follows: the door is closed on both the past "with its regrets and remorse," and on the future, defined as the alcoholic's "castles in Spain"; the final result is that the member, through re-defining his "huge, complex life-problem as a simple task of here and now . . . adopts this formula for cutting life down to a size he can grapple with in all his affairs."

With all the advantages A.A. offers, one cannot resist speculating on what characterizes those potential recruits and "slipees" who are unable to profit from membership. A.A.'s explanation is that only two types fail to "get A.A.": (1) those who "aren't ready to quit" and (2) those "who are constitutionally unable to be honest with themselves,"[4] presumably psychopaths. This theory cannot be wholly correct in view of the countless cases who have failed A.A. only to achieve sobriety through conditioned-reflex therapy, a method that also rules out both types as unfit candidates.

The search for an explanation is problably fruitless, but one intriguing hypothesis is offered by Jellinek.[5] In A.A. one finds the modal personality at its peak. . . . This identification is a source of strength and may be a weakness. For those who, for any of a dozen reasons, cannot merge with the

[1] See *Alcoholics Anonymous,* previously cited.

[2] See Carroll, *op. cit.*

[3] See "A.A.," *loc. cit.*

[4] See *Alcoholics Anonymous,* previously cited.

[5] See "Phases in the Drinking History of Alcoholics," by E. M. Jellinek. *Quarterly Journal of Studies on Alcohol,* Vol. 7 pp. 1–88, June, 1946.

group pattern may not fare well. The non-selectivity of A.A. may work to the disadvantage of the individual."

Be that as it may, general opinion seems to be fairly well reflected in Silkworth's statement that A.A. marks "a new epoch in the dark annals of alcoholism."[1] One thing is certain: while first-class conditioned-reflex therapy and psychiatry remain so prohibitive, either because of unavailability or because of cost, the "common man" will choose A.A. or alcohol.

In connection with the discussion of A.A., it might be well to allude briefly to the use of group psychotherapy in the treatment of alcoholism. This is a relatively recent practice which has gained great momentum since it was popularized on the layman level by A.A. In recognition of the benefits of coöperation with A.A., many doctors have reached the conclusion expressed by Fox:[2] "One of the most important factors in therapy is placing the patient in contact with other alcoholics." Sharp[3] finds this method "peculiarly suited to alcoholic character disorders"; and McCarthy[4] adds: "Also, the leader can evaluate him socially as he sees his reactions to the group (not possible in individual treatment)."

Two specialized forms seem to be gaining adherents in therapeutic circles: recreational therapy and psychodrama. In the former, the therapist joins the patients in group athletics. In this way rapport is enhanced and, in addition, according to Davis,[5] "the patient obtains relaxation and can reëducate himself emotionally, for defeat and victory are accepted more readily on the sports level." Psychodrama provides the patients with the opportunity of experiencing catharsis and gaining insight through a combination of audience and action rôle-taking activities and "carefully timed analysis by the director."[6]

[1] See *Alcoholics Anonymous*, previously cited.

[2] See "Medical Progress; Newer Treatment of Alcoholism," by R. Fox. *New York Medicine*, Vol. 1, p. 11, March 5, 1945.

[3] See Sharp, *op. cit.*

[4] See "Group Therapy in an Outpatient Clinic for the Treatment of Alcoholism," by R. G. McCarthy. *Quarterly Journal of Studies on Alcohol*, Vol. 7, pp. 98–109, June, 1946.

[5] See Davis, *op. cit.*

[6] See "Psychosomatic Therapy for the Alcoholic," by M. Tierney. *Sociometry*, Vol. 8, pp. 76–8, February, 1945.

In accordance with sociopsychiatric principles and A.A. experience, the adaptation of group therapy to the field of alcoholism treatment should produce good results, but at the present time corroborative studies are, as usual, lacking.

Synthetic Treatment.—As in the field of child guidance, those on the frontiers of alcohol-therapy effort came to see the necessity of adopting the "total approach" to the problem. Jellinek[1] tells us that the end result of physiological research at Yale was the realization that alcoholism is a much more complex problem than had been imagined and that "research in other branches of science had to be integrated.... Too many problems have remained unsolved because they have not been approached with the respect which their magnitude demands." Carlson[2] sums up the situation by saying that "there is no alcoholic personality and no special single type of successful therapy."

Knight, who, it will be remembered, achieved such unenviable results when employing psychoanalysis alone, is credited by Kersten[3] with voicing the new orientation: directing therapeutic effort toward "the total man in the total environment." His concept has been tested at the Winter Veterans Hospital, where the program includes psychotherapy, group therapy, coöperation with A.A., and social-service follow-up. The results of the changed approach are judged as "good," whatever that may mean.

It is significant that Dr. Knight was forced to abandon accepting coerced and deceived patients, and to cut hospitalization time down to approximately three months. "It is wasted effort," Kersten observes, "to try to dissuade a patient from leaving." Moreover, "In a sincere patient a slip may lead to improved results. In the insincere it may lead to a change of attitude." Davis[4] supports the more permissive attitude in commenting: "After long-term hospitalization the patient usually reverts and all is useless. After enforced

[1] See "The Alcohol Problem Dissected," by E. M. Jellinek. *Social Action*, Vol. 11, pp. 5–34, March 15, 1945.

[2] See "The Complex Causes of Alcohol Addiction," by A. J. Carlson. *Proceedings Institute of Medicine, Chicago*, Vol. 16, pp. 251–53, November 15, 1946.

[3] See "Changing Concepts of Alcoholism and Its Management," by P. M. Kersten. *Quarterly Journal of Studies on Alcohol*, Vol. 9, pp. 523–31, March, 1949.

[4] See Davis, *op. cit.*

short-term hospitalization the patient is bitterly resentful and flees to drink for relief."

Some experts hold that Dr. Knight's psychologically focused program omits consideration of the physiological aspect of the "total man." Thus we find treatment procedures typified by the Washingtonian Hospital fourfold program,[1] which includes conditioned reflex, psychotherapy, hospitalization, and social service. Psychotherapy is dispensed with where unnecessary, and the hospitalization is unique, being full-time at first only. Later, according to needs, the patient may remain there nights and week-ends, often while environmental manipulation proceeds. Social service may include finding the individual a job and social case-work with the family, especially the mate. Interestingly, "the prognosis is poor when a wife is neurotic or dominating."[2]

Thimann[3] states: "This [synthetic treatment] is believed to be the most promising treatment." A 1947 study of 126 patients reports that "of 53 treated in 1942, 45 per cent are still abstinent; of 26 in 1944, 88 per cent; and of 47 in 1947, 74 per cent." Welcome figures indeed. Williams[4] considers a similar treatment combination more effective than other methods. A three-year follow-up of 18 cases showed only two to have relapsed and, of these, one was a hopeless psychopath.

We come at last to what is undoubtedly the most realistic and inclusive effort in the whole field—not so much in the sense of the number of specifics employed (for in neglecting conditioned reflex it might be argued that part of the *total alcoholic* is ignored), but in the crucial sense of attempting to reach the *totality of alcoholics*—the Yale Clinic Plan.

Although Yale researches have concentrated on prevention, the need was recognized for free medical treatment for alcoholism on a national scale. Originating in Yale's New Haven Clinic, the movement is gradually spreading over the country.

[1] See "Modern Trends in the Treatment of Alcoholic Addiction," by J. Thimann and Gladys M. Price. *Journal of Social Casework*, Vol. 27, pp. 222–29, October, 1946.

[2] *Ibid.*

[3] See "The Conditioned Reflex Treatment of Alcoholism," by J. Thimann. *New England Journal of Medicine*, Vol. 228, pp. 333–35, March 18, 1943.

[4] See Williams, *op. cit.*

According to McCarthy, Executive Director of the Yale Plan Clinics, heretofore selection has operated to bar the alcoholic masses from treatment, whether because of the cost of sanitaria, the paucity of psychiatrists, the limitations of the general practitioner, or the regulations of mental hospitals. (A.A. unintentionally selects, too, for it is felt that many shy or proud individuals hesitate to join.)

The experience of the clinics at New Haven and at Hartford has proved to the staff's satisfaction that "while there is a place in a big public program for institutional supervision and treatment" (of the psychopathic, psychotic, and feebleminded), most alcoholics "represent a cross section of society" and are in need of relatively few individual psychiatric consultations. They can be straightened out on an ambulatory basis, if they are seen frequently by psychiatric workers and other staff members and join in therapeutic groups.

The staffs are composed of physicians, psychiatrists, psychologists, and case-workers. Treatment and practical help involve medication and guidance, oriented toward enabling the patient to understand his problem and cope with his environment. Often the environment shares the focus.

Haggard[1] reports that the success rate is 80 per cent for those who go through with the program, while the mean per capita cost to the state is only $68.00. Two factors seem to account for what is, as far as the present author can ascertain, the highest substantiated percentage of recovery: (1) "the ingenuity of the staff" and (2) "the vast information compiled by the University's Section on Alcoholism Studies." And while treatment stresses mental hygiene, the staff, unlike that of an ordinary psychiatric clinic, recognizes the crucial fact, stated by Dr. McCarthy,[2] that "the alcoholic resents being called a 'mental case' and the families feel much the same, through misunderstanding psychiatry. . . .

"It is generally accepted that there is no alcoholic person *per se*. Of greater significance, there is no alcoholism as such.

[1] Quoted in item, "Modern Medicine in the Treatment of Alcoholism," in the *Journal of the American Medical Association*, Vol. 134, p. 468, May 31, 1947.

[2] See "A Public Clinic Approach to Certain Aspects of Alcoholism," by R. G. McCarthy. *Quarterly Journal of Studies on Alcohol*, Vol. 6, pp. 500–14, March, 1946.

Instead, there are thousands . . . of friendly, coöperative people who recognize they shouldn't drink alcohol, but admit their inability to refrain from its use. . . . To reorganize all these individual lives, there is no single therapy. The public clinic, by coördinating the activities of the psychiatrist, internist, psychologist, and psychiatrically trained worker, and by using the services of hospital and laboratory facilities and consultants in other fields can approach the problem with a range of diagnostic and remedial skills capable of dealing with the individual differences of inebriates."

This formulation bears slight resemblance to those of the sin and apples schools. We have come a long way.

FAMILY GROUP THERAPY IN THE CHICAGO COMMUNITY CHILD-GUIDANCE CENTERS*

RUDOLF DREIKURS, M.D.
Professor of Psychiatry, Chicago Medical School

THE Community Child Guidance Centers of Chicago use group methods, as do most child-guidance clinics that follow the techniques developed by Dr. Alfred Adler.[1] Group therapy in these centers is a unique combination of group dynamics, with the group approach taking place at various levels: *the family group,* in which we deal with the entire family in each case rather than with the mother or the child alone; *the children's group* in the game room, where we supplement play with psychodrama as a further group approach; *the parents' group,* composed of parents enrolled for therapy, who participate in group discussions; *the community group,* composed of visiting parents, teachers, students, and others interested in problems of child guidance, who likewise participate in the discussion; *children among the adults,* being interviewed in the counseling room in the presence of adults—one of the most interesting, and perhaps most controversial, aspects of our group therapy.

Each group situation, interrelated with all the others, presents its own dynamics.

1. *The Family Group.*—Because we recognize that the problems of the child result from interpersonal relationships in the family group, we deal with all family members at the same time. Wherever possible, all adults in a household are drawn into the counseling session. Frequently, however, the mother is the only one willing to come, though fathers are now taking part more and more. Even if they are reluctant to come at the start, as their children show the first signs of improvement, fathers become more willing to attend. This holds true as well for grandparents and other relatives who

* Presented at the Seventh Annual Conference of the American Group Therapy Association, New York City, January 14, 1950

[1] See *Guiding the Child,* by Alfred Adler. New York: Greenberg, Publisher, 1931.

initially resist coming, but are eventually drawn in. We always insist on the participation of *all* the children in the family.

Discussion and therapy deal with the dynamics that operate within the family. Since the problems of the child express his *inter*personal conflicts within the family, rather than any *intra*personal conflict, the counselor deals with all members of the family who unwittingly take part in the conflict. This approach leads to quicker results and better understanding of the factors responsible for the disturbance.

The child's behavior, regardless of how much disturbance it causes or how abnormal it may appear, must be considered a logical answer to the situation in which he finds himself. First of all, his behavior is a response to the mother's attitudes and her methods of dealing with him and is interrelated with the behavior of his siblings. Sometimes, the "problem" child is not the real problem at all; his apparently "good" and well-adjusted brother or sister may be the source of the disturbance.

Examination of the family setting may reveal peculiar conditions which explain the child's reaction and behavior. The basis of the problem may be a conflict between the parents, the child being used as a pawn; or it may be a conflict between the mother and the grandmother. A mother may be involved in a fight with two men of the family, such as a son and the father; or she may be squeezed out by an alliance of a grandmother with the child. In one case, a child's rebellion and unruliness arose from the fact that the mother allied herself with two older daughters against a younger child.

It is impossible to classify the different configurations within families. But in each case interpersonal dynamics are exposed and explained to all the participants and new relationships are stimulated. Therapy consists of these interpretations and suggestions of methods for dealing with each problem. The prime objective of all suggestions is to change existing relationships.

As a rule, counseling of adults is conducted separately from the discussion with the children. When children enter, the adults in the family leave the counseling room. In many instances, the adults are called back in before the children leave, so that part of the discussion is conducted with all

members of the family together. In this way, everybody is given a chance to express his feelings openly and frankly. In the ordinary family setting, this kind of open discussion of attitudes and feelings is impossible because every statement may lead to quarreling. The counselor helps maintain a calm atmosphere of objectivity and interprets the position of each to opposing members of the family. This discussion of mutual problems in a democratic spirit of respect leads to better understanding all around. It begins the "family council," a technique instituted in most cases to carry on the therapeutic approach as part of daily family life.

2. *The Children's Group in the Game Room.*—As parents and adults belonging to the community assemble in the counseling room, children remain in a separate game room.

In child-guidance centers conducted in Europe, children sat with their parents in the counseling room; it permitted them to acquire an understanding of problems from the point of view of parents and adults. This procedure, tried here when the first center opened eleven years ago, proved impracticable because the children became restless. Since then, only occasionally is an older child invited in to sit with the grown-ups.

The game room was established as an adjunct to the counseling center, as a place in which each child is observed in his relationship to other siblings and children. In the permissive atmosphere of this setting, the child openly expresses his attitudes and approaches, and the group worker has an opportunity to make observations of the child to report to the counselor.

Group therapy in the game room is not limited to the stimulation of free expression. To facilitate reorientation of the child, therapy is coördinated with psychodrama as developed by Moreno.[1] The psychodramatist enacts with the children characteristic domestic and social problems to lead them to recognize their particular attitudes and approaches and to reëvaluate both. Action experience supplements verbalization in counseling.

Both group worker and psychodramatist integrate their approaches to the child and maintain close contact with the counselor, with whom they exchange observations in the

[1] See *Psychodrama*, by J. L. Moreno. Beacon, N. Y.: Beacon House, 1946.

counseling room in the presence of all parents and participants. The counselor directs both in their therapy by supplying them with information about the basic psychodynamics of each child. The procedure in the game room can best be described as "activity group therapy."

3. *The Parent Group.*—Entirely different group dynamics come into play in the discussion with parents enrolled in the program. Not only do they attend sessions when their own cases are scheduled for interview—arranged, in accordance with the severity or urgency of the case, every two or four weeks—but they are obliged to attend each session. Their regular participation is important for their own reorientation and the help they give those other parents whose cases are being discussed.

This form of group therapy provides parents with an opportunity to understand their own problems better and more easily, as problems similar to their own are discussed with other parents. Although it is difficult to see ourselves objectively, we have no blocking in understanding a problem clearly when some one else is faced with it.

The group helps parents both directly and indirectly. At any point at which a parent has difficulty in seeing what he is doing to the child or what he could do differently, some other parent may volunteer to report a similar experience in his own family and the methods used and solutions found. More important than the direct contribution is the emotional and impulsive reaction of the group to statements and attitudes expressed by parents during the consultation.

Counseling is thus no longer a private affair between parents and counselor, with all its limitations and the difficulties arising from a possible feeling on the part of the parent that he is misunderstood by the counselor or from his questioning the validity of the opinion of one individual—the counselor. In place of the counselor-client relationship, from which autocratic—and, therefore, detrimental—elements are not always eliminated, the client is exposed to group pressure which he can accept more easily.

Another indirect influence of great importance is realization by each parent that he shares his problems with many others. Feelings of shame, humiliation, guilt, or personal inadequacy are removed, as parents recognize that their problem is a

universal one. The group situation provides a convincing experience of the fact that almost all parents have problems with their children, that one's own child is no worse than many others, and that it is normal for the children of to-day to have more or less serious troubles. With this recognition, parents completely lose any embarrassment over their own "failure."

4. *The Community Group.*—Characteristic of this form of child guidance is the effort to reach and to affect the entire community in its attitude toward and methods of dealing with children. Participation in the discussion by visiting parents, teachers, social workers, and others interested in children who represent the community affects principles of education in the specific community, and techniques used in the local schools, in the home, and in community agencies.

Frank discussion of a parent's problem, in the presence of his neighbors, friends, the child's teacher, his clergyman, and his physician, influences the concepts prevailing in the community. The wide range of economic status and of racial and religious variations within the participating community group also affects group dynamics within the community at large, by promoting mutual respect and coöperation.

This setting has been the subject of some criticism. It must be admitted that unless one has attended such sessions, it is hard to imagine its effects. Although one may doubt that parents will speak up frankly without embarrassment before others, the fact is that they *do* express themselves frankly. Most of the material presented is not of an intimate nature, the conflicts discussed reflecting general interpersonal relationships and not matters that cannot be divulged publicly. Where such factors are important in a specific situation, parents have the opportunity to discuss them privately with the social worker or the counselor.

Our guidance centers, until a few years ago, were conducted exclusively in underprivileged areas. Even though we doubted whether the same methods could be applied to a middle-class or upper-middle-class community, two years ago such a center was opened. We did not know whether parents in the new area, because of their extreme competitiveness or concern for their own prestige before neighbors and friends, would hesitate to use the center. But our experience demonstrated that these parents behaved in the same way as any others.

In fact, attendance was much larger and requests for service greater, since parents there recognized their own need for help more readily. We took the precaution of not interviewing a parent before he had attended several sessions. Embarrassment was not noticeable, and if it occurred, it disappeared within a few minutes. Within a short time, the entire community became aware of the amount of help needed by almost every parent. Schools in the area took a more active part, since the parent-teacher relationships in the area were cordial and close.

A number of precautions must be taken to permit community group therapy. All-important is it that the proper spirit prevail, so that those who attend truly form a group and do not act merely as spectators or onlookers. The counselor or group leader must watch the group atmosphere carefully and be sensitive throughout the session to any disturbance in group spirit.

A great deal depends on the seating arrangements and size of the group. Some visitors express the intention to come as "outsiders" or "onlookers" by sitting in the rear or at the sides. Seating must be inclusive so that all participants form one body. Private conversations that disrupt group cohesion must be eliminated. The group leader must meet any distraction, loss of interest, antagonism, or aloofness through proper action. It is interesting to note that the size of the group depends not only on the condition of the room and the nature of the participants, but also on the personality of the counselor.

The number of persons who can be handled can be gauged quite accurately. In our experience, a group of about 100 can be integrated if seating facilities permit a solid semicircle. It is advisable that nobody sit more than three or four rows away from the group leader. The counselor has to be able to see everybody, not only to catch any indication of desire to participate, but also to recognize and deal with emotional reactions, confusion, objection, or criticism. Actually, while counseling one parent, he is simultaneously dealing with the group.

By and large, the group comments and the questions raised usually conform to the requirements of coöperation. Occasionally some difficulties arise when a professional worker

or student expresses antagonism and tries to involve the counselor in an argument. Although theoretical questions lend themselves readily to a clarifying discussion, the counselor must keep in mind that if he responds in kind to any antagonism, the entire group is detrimentally affected, since all emotional expressions are magnified in a group experience.

We had some difficulty with medical students who for a while were regularly assigned to the guidance centers. Sometimes they strayed by trying to counsel a parent on their own, in disregard of the counselors. Where a participant differs from the counselor, he can safely express his difference without disturbing group spirit by addressing the counselor instead of the client directly. These and similar devices can stimulate the feeling of belonging among participants. Since the material discussed is frequently of highly emotional significance, group experiences often take the form of genuine spiritual experiences.

5. *The Child in the Adult Group.*—The unusual setting of the presence of children in the counseling room is a most interesting and important aspect of our guidance centers. On this point, our methods have met their most severe criticism. Opposition by case-workers, experienced by all group therapy in the country, concentrates on this particular aspect. Case-workers assume that the child is harmed by the experience. But it is a matter of fact that the technique has been practiced for more than twenty-five years and no case of harm to a child has yet been brought to our attention. On the contrary, the few minutes spent with the child in this situation seem to produce deeper and more constructive impressions than anything else we have so far tried. By this method the child is reached more easily, and quicker results are obtained, than by individual counseling in our private office. The group dynamics of the situation deserve close attention and recognition.

When the child and his siblings enter the counseling room, they are confronted with a group of strangers, sometimes quite numerous, and—if this is the first interview—with the counselor, whom they have not met before. This situation certainly is "strange" to them. But the effect of the strangeness is both profound and extremely helpful. Contrary to

the assumption that the child is not "himself" in a perplexing atmosphere, it has been repeatedly found that he expresses himself more accurately than in the familiar surroundings of home or school, where he may hide behind well-established approaches.

We have published cases [1] in which the behavior of children entering the room immediately pointed to problems diametrically opposite to those previously observed by parents and teachers. The "problem" child may show a completely adequate performance and adjustment and the hitherto well-adjusted sibling suddenly reveal his maladjustment.

Although the diagnostic and therapeutic efficiency of the situation is obvious, doubt may still remain as to the child's reaction to the setting. Any one who has ever attended the sessions can confirm the amazing fact that children are completely at ease, with the exception of a restless or shy child whose behavior always remains the same. Particularly astonishing are the friendliness and frankness with which children immediately begin to talk to the counselor.

Their positive response to an adult group may best be explained by the prevalence of attention-getting devices, particularly among young children. They want to be the center of attention and seldom have the chance to be so much the center as in this situation. Many who are exhibitionist and show-offs immediately sense their opportunity. The impressive setting enhances their willingness to listen to the counselor, in contrast to our experience in a private office, where they are often on guard against any adult from whom they expect scolding and criticism, or at least preaching. In the counseling room, they immediately realize that this situation is different.

Because of children's sensitivity, they immediately respond to a group atmosphere characterized by interest, sympathy, and a desire to help. They are treated as equals from the outset, a new experience that overcomes any barrier they may have set up for themselves before coming into the counseling room.

In our experience, nowhere is every move of the child so

[1] See *The Challenge of Parenthood*, by Rudolf Dreikurs. New York: Duell, Sloan and Pearse, 1948.

characteristic of his deeper social attitudes and approaches as in the dramatic, impressive moment when he enters the room. The way in which he moves—particularly the physical contact with or distance from his siblings—the manner in which the children in the family range themselves on the bench, all openly reveal relationships of one to the others.

A short discussion with the counselor centers around a few leading questions as to the child's relationship to others and an interpretation of his goals. Changes in the child's condition, improvement or relapse, are made plain by his behavior, his deportment, and his facial expression. These observations are checked with those made on the child in the game room and in psychodrama, which may or may not agree with reports by his parents, since a parent is often the last person to evaluate any change properly. The parent may be overcritical and not notice an obvious improvement; or he may already have made some adjustment himself without significant changes occurring in the child and report a subjective improvement not justified objectively, sometimes merely to impress the group with his or her "ability."

There is a strong interaction between the children and the adults present. Both contribute greatly to their mutual benefit. What does the child contribute to the group? Most impressive is the realization by all the other parents of how much more easily the child understands the nature of his troubles and problems than do his parents. The latter strongly resist any interpretation out of line with their more or less fatalistic assumption of causes that do not exist. Children's sensitivity to psychological understanding and their response to psychological interpretation contrast impressively with the obvious lack of similar qualities in their parents.

A child's exhibition of the "recognition reflex,"[1] when the goal of his behavior is disclosed to him, is often both dramatic and convincing to those in doubt about the counselor's previous attempt to explain the child's behavior to his parents. Discussion with children is generally most enlightening to adults, as the more pertinent and fundamental issues arise in

[1] See Dreikurs, *op. cit.*

discussion, while in contrast a great deal of time is spent on insignificant issues with the child's parents, who fasten their concern on symptoms rather than causes.

What does the group offer to the child? As already mentioned, the group provides a setting for a psychologically significant experience to the child. Throughout the interview, he responds to the group as he talks with the counselor. Many of the child's remarks are for the benefit of listeners. There is constant intercommunication, by which the group is tested as much as the child.

As the entire group participates, outwardly listening quietly, some adults are compulsively carried away by their own faulty attitudes toward children. If a child plays stupid, and the counselor understands and ignores it, some mother may feel compelled to come to the child's aid. The discussion of such a transgression that follows is equally important for the child and for the others. Some adults have difficulty in sensing a child's goals and provocations, and do not know when to fall for them and when to ignore them.

With the leadership of the counselor, the group "learns" to behave; the child is then impressed with the new experience. It is important, for example, to know when to laugh at what the child says or does and when not to. By and large, those who attend sessions for any length of time know when to laugh as the child plays to the gallery, and when laughing would be out of place. Only newcomers infrequently violate this psychological need. Generally, the group treats the child as an equal and behaves "properly," an experience seldom offered a child growing up in this era.

CONCLUSIONS

Child-guidance centers, operating in the manner described, offer a wide range of group approaches and dynamics. Their effectiveness demonstrates that a non-selective group can be drawn into and readily accept group therapy. It is more effective than individual therapy and provides a therapeutic medium most important at a time when the available number of professionally trained workers is grossly inadequate for the urgent needs of individuals and groups.

The four centers operated by the Community Child Guidance Centers of Chicago, each meeting once a week, had under treatment during the last fiscal year 133 families, including 297 children. The total attendance at the centers during this year was 3,274, of which 484 were teachers. This program required the full-time services of one social worker and one clerical worker, the part-time service of a group worker, and less than part time from the counselors (two psychiatrists and one psychologist), the clinical psychologist who gave the tests, and the psychodramatist, plus a number of volunteer assistants.

The psychological help rendered by the centers reached far more than the parents and children under treatment. The benefits derived from mere attendance can be evaluated from frequent remarks of mothers who had attended sessions for some time that their problems had been solved before they made even an appointment for an interview. With participation by teachers, a much closer understanding is achieved between teachers, parents, and child. The whole community responds to the stimulation by the center, which is much discussed and affects the prevalent concepts about educational methods and the value of dynamic psychology and psychiatry.

BOOK REVIEWS

PSYCHOANALYSIS AND RELIGION. By Erich Fromm. New Haven: Yale University Press, 1950. 119 p.

Some psychoanalysts, like Freud, dismiss religion as an illusion, nothing more than a symptom of unsolved emotional conflict. Others, like Jung, find in the Unconscious certain data to which they give a religious interpretation. A third group, like the author of this book, already known for his *Escape from Freedom* and *Man for Himself*, finds both in religion and in non-religious symbol-systems (*e.g.*, patriotism) human realities which psychoanalysts can study, enlighten, and help direct toward nobler living. He is closer to Freud than to Jung, but objective enough to treat the latter without prejudice. With Freud, he sees where traditional religions have often sanctified bad human institutions, improverished intelligence by prohibiting critical thinking, and endangered moral advances by tying them up with questionable belief in God. Therefore, to reduce suffering and promote sound morals, he pleads for an ethics that he holds can stand upon its own feet. Man has nothing to rely upon but his own (often unused) powers. When he wakes up to this truth, he will learn to use these potencies wisely.

Fromm scores by showing how traditional religionists ignore the many world religions outside of monotheism and make their own God-centered belief the only frame of reference. Because not only Buddhism, Taoism, Confucianism, but also secular inspirations like Nationalism, Fascism, and Communism have moved their millions, Fromm broadens the meaning of the term, religion, to "any system of thought and action shared by a group which gives the individual a frame of orientation and an object of devotion."

The need for such orientation and devotion is an intrinsic part of human existence. Since every normal person has "ideals" of one kind or another, his main business is not to choose between having or not having objects of devotion, but to select those that do most to promote reason, justice, love—the emergence, in short, of all those attributes most to the credit of mankind.

> "Man may worship animals, trees, idols of gold or stone, an invisible god, a saintly man, or diabolic leaders; he may worship his ancestors, his nation, his class or party, money or success; his religion may be conducive to the development of destructiveness or of love, of domination or of brotherliness; it may further his power of reason or paralyze it; he may be aware of his system as being a religious one, different from those of the secular realm, or he may think that he has no religion and

interpret his devotion to certain allegedly secular aims like power, money, or success as nothing but his concern for the practical and expedient. The question is not *religion or not*, but *which kind of religion*, whether it is one furthering man's development, the unfolding of his specifically human powers, or one paralyzing them."

Conceiving religion in this broad sense, Fromm finds in contemporary western society, under a veneer of Christianity and atheistic and agnostic philosophies, too, many primitive religions:

"As a collective and potent form of modern idolatry we find the worship of power, of success and of the authority of the market; but aside from these collective forms we find something else. If we scratch the surface of modern man, we discover any number of individualized primitive forms of religion. Many of these are called neuroses, but one might just as well call them by their respective religious names: ancestor worship, totemism, fetishism, ritualism, the cult of cleanliness, and so on.

"Do we actually find ancestor worship? Indeed, ancestor worship is one of the most widespread primitive cults in our society and it does not alter its picture if we call it, as the psychiatrist does, neurotic fixation to father or mother. . . .

"Do we have totemism in our culture? We have a great deal—although the people suffering from it usually do not consider themselves in need of psychiatric help. A person whose exclusive devotion is to the state or his political party, whose only criterion of value and truth is the interest of state or party, for whom the flag as a symbol of his group is a holy object, has a religion of clan and totem worship, even though in his own eyes it is a perfectly rational system (which, of course, all devotees to any kind of primitive religion believe). If we want to understand how systems like Fascism or Stalinism can possess millions of people, ready to sacrifice their integrity and reason to the principle, 'My country, right or wrong,' we are forced to consider the totemistic, the religious quality of their orientation."

Of all the differences among these many "religions," for Fromm the most important to-day is that between authority and humanism:

"The essential element in authoritarian religion and in the authoritarian religious experience is the surrender to a power transcending man. The main virtue of this type of religion is obedience, its cardinal sin is disobedience. Just as the deity is conceived as omnipotent or omniscient, man is conceived as being powerless and insignificant. Only as he can gain grace or help from the deity by complete surrender can he feel strength. Submission to a powerful authority is one of the avenues by which man escapes from his feeling of aloneness and limitation. In the act of surrender he loses his independence and integrity as an individual but he gains the feeling of being protected by an awe-inspiring power of which, as it were, he becomes a part."

"In humanistic religion God is the symbol of what man potentially is or ought to become."

"Man is indeed dependent; he remains subject to death, age, illness, and even if he were to control nature and to make it wholly serviceable to him, he and his earth remain tiny specks in the universe. But it is

> one thing to recognize one's dependence and limitations, and it is something entirely different to indulge in this dependence, to worship the forces on which one depends. To understand realistically and soberly how limited our power is, is an essential part of wisdom and of maturity; to worship it is masochistic and self-destructive. The one is humility, the other self-humiliation."

Ideas like these find wider acceptance to-day than they did when Freud began writing. For instance, for seventy-five years ethical-culture societies have established institutions for teaching them and applying them in practice. Growing numbers of persons no longer feel the older need of membership in church or temple.

More likely to arouse dissent among psychologists is Dr. Fromm's view of the ethics in the central devotion or aim which psychoanalysts can help to clarify and direct. He calls psychoanalysis religious in searching for truth as the surest way to the curing of souls. For this reason he differs with those physicians who are content to help a patient make a "normal" adjustment to his environment. What if the normal standards are commercial, crass, authoritarian, superstitious? A fool is more contented when he behaves just like every other fool. But both he and they are still untrue to themselves. They have capacities for reason and love which our world needs sorely; and it is the releasing of these, the asserting of candidacy for membership in a truly ideal order rather than adjustment, for which Dr. Fromm pleads eloquently. He understands of course how such release may result in unhappiness for the deviate. But he does well to remind us that because the need for the better releases nevertheless does exist, the problem of psychologic service lies deeper than many practitioners seem to be aware.

At one or two points he seems to overestimate the part played in the lives of extroverts by his own introvert inspirations. But on the whole, battling as he does on two fronts, against the claim of traditional religionists to a monopoly of ethical motivation, and against the contentment of some psychoanalysts with mere adjustment, he strikes this reviewer as eminently deserving of attention.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

THE PSYCHOLOGY OF ABNORMAL BEHAVIOR, A DYNAMIC APPROACH. By Louis P. Thorpe and Barney Katz. New York: The Ronald Press, 1948. 877 p.

THE ABNORMAL PERSONALITY, A TEXTBOOK. By Robert W. White, New York: The Ronald Press, 1948. 613 p.

The books and monographs that may be described as essential for an understanding of the broad field of abnormal psychology can be

counted into the hundreds. The texts on abnormal psychology for undergraduate students that may be described as satisfactory can be counted on the fingers of one hand. The two volumes under review are, accordingly, most welcome. Both are texts addressed to undergraduates. Both hope to be useful to other readers. Both are offered as texts for other courses in mental hygiene, clinical psychology, or personality adjustment. Both claim to present dynamic points of view. Both are eclectic in recognizing and explaining divergent theories and interpretations. Nevertheless, the two volumes are utterly different.

The contrasts are most readily apparent in the introductory historical chapters, which cover essentially the same topics. Thorpe and Katz seem to give more detail in a brief chapter of only seventeen pages. Their exposition is badly marred, however, by organization according to countries. Thus, they discuss eighteenth-century contributions from England, France, Germany, and the United States, and, again, more recent contributions from Germany, France, Austria, Hungary, Switzerland, England, Russia, Italy, and the United States.

In a much longer introductory historical chapter of 51 pages, White traces changing attitudes toward the insane and follows this with a discussion of three historical problems. The first of these centers around the symptom-complex of delusions of grandeur, dementia, and progressive paralysis, first clearly described by Haslam in 1798. The slow, yet dramatic progress over more than a century in tracing the causes of these symptoms to syphilis provides a story that not only gives a factual background, but that should inculcate scientific attitudes, arouse interest, and inspire.

In like manner Kraepelin's contribution is introduced as a problem in the ordering of symptom-complexes. Both the historical importance and the present limitations of Kraepelin's ideas are clearly presented. Again, the problem of hysteria provides the organizing focus for the work of Mesmer, Charcot, Janet, Breuer, and Freud.

Similar contrasts appear in the introductory clinical sections that feature both volumes. Thorpe and Katz begin their initial chapter with five pages devoted to two case studies. One case, a combat pilot, illustrates the fact that even the well-adjusted will break if the stress is severe enough; the other, a housewife, illustrates the point that much milder stresses long continued from early childhood may be responsible. Neither case is interpreted, nor is either referred to in later sections. These cases are reported in fine print with the details carefully pigeonholed under the headings: *Present Difficulty, Family History, Personal History, Medical History, Educational History, Vocational History,* and so on. Most of the 118 cases in Thorpe and Katz follow this uniform pattern of reporting. After these cases the

exposition shifts abruptly to the incidence and costs of psychological disorders.

White's clinical introduction runs to 47 pages. Five cases—an adolescent maladjustment, a neurosis, a criminal career, a psychosis, and a degenerative brain disease—are presented in detail. These cases are not reported in fine print. Nor are the specific facts of each pigeonholed under uniform headings. Apparently White believes that case histories should be read as carefully as the text. All five cases are interpreted at length. More important, constant reference is made to these and to additional cases throughout subsequent chapters. From an instructional point of view—that of seeking to develop student understanding of mental disorders—these five cases are superior to any of several dozen stereotyped case reports in Thorpe and Katz.

The contrasts between these roughly comparable sections are characteristic and need not be extended to additional sections. The treatment in Thorpe and Katz is traditional, textbookish, and subject-matter-and-symptom-oriented. The literature is copiously quoted, but divergent views are rarely evaluated or reconciled. Always the discussion is meticulously outlined, but the organization is typically mechanical and often irrelevant.

The preoccupation with definitions, technical terms, and minor distinctions appears in extreme form in the six chapters on symptoms. Thus, Chapter X, on motor symptoms, covers eighty technical terms including *astasia-abasia, cerea flexibilitas, dysarthria, aphemia pathematica,* and *amimia* in the space of only eleven pages! The appendix contains in addition a twenty-page glossary of approximately five hundred terms. The main body of the text, Chapters XIII to XXIX, totaling nearly five hundred pages, presents systematic discussions of over two hundred behavior abnormalities. To the extent that data are available, each of these follows a uniform plan, consisting of an introductory paragraph, often a case history, and separate paragraphs, each with a topical heading in distinctive type, on incidence, symptoms, etiology, pathology, diagnosis, treatment, prognosis, and prevention.

Chapters XXX to XXXIV discuss principles and techniques of therapy. The encyclopedic scope of the treatment is notable. There is a chapter or section or paragraph on every etiological factor, every symptom, every abnormal condition, and every therapeutic method. At the same time—or so it seems to this reviewer—the text helps the student to understand nothing.

White's volume may be most accurately characterized by quoting the first paragraph of his preface (italics are the reviewer's):

> "My purpose in this book is to write about abnormal people in a way that will be *valuable and interesting* to students new to the subject.

> This purpose has guided the many decisions, particularly as regards what to put in and *what to leave out*, that go with writing a textbook. A first course in abnormal psychology is not intended to train specialists. Its goal is more general: *it should provide the student with the opportunity to whet his interest, expand his horizons, register a certain body of new facts, and relate what he learns to the rest of his knowledge about mankind.* The value of a course in abnormal psychology is not, in my opinion, limited to those who plan to become professional workers with abnormal people. I have tried to present the subject in such a way as to emphasize its usefulness to all students of human nature."

This statement of purpose is commended to all who would write for undergraduates. It needs only to be added that White's text contains no baby talk. It is solid and scholarly throughout.

His introductory historical and clinical chapters are followed by two chapters on the development of the normal personality, showing at many points how development can go astray. Chapters V to VIII discuss the neuroses, beginning with the simplest forms in fantasy, dreams, and hypnosis and ending with anxiety states, phobias, obsessions, dissociated conditions, and hysteria. Two chapters on therapy follow. Delinquency and psychosomatic and organic disorders are presented in Chapters XI, XII, and XIII. Two chapters are devoted to the psychoses. The final chapter states the general problem for the psychiatrist, the psychiatric social worker, the clinical psychologist, the citizen, and society.

FRANK K. SHUTTLEWORTH.

The City College of New York.

SEARCHLIGHTS ON DELINQUENCY: NEW PSYCHOANALYTIC STUDIES. Edited by K. R. Eissler and others. New York: International Universities Press, 1949. 456 p.

The aim of this book, which consists of a series of thirty-four papers, is to offer a representative cross section of the literature on the psychoanalytic theory and treatment of delinquency. It is dedicated to Professor August Aichhorn, of Vienna, on the occasion of his seventieth birthday, July 27, 1948. In it his friends and pupils present various points of view and indicate the tremendous influence that the pioneer work of Aichhorn has had on them. The book includes the following headings: *Introduction;* I, *General Problems;* II, *Clinical Problems;* III, *Technique and Therapy;* IV, *Etiology and Development;* V, *Social Psychology;* VI, *Penology;* and VII, *Surveys.*

The approach to the problem of delinquency has been definitely changed as a result of the general psychoanalytic principles that Aichhorn postulated and the recommendations that he offered in terms of specific variations and adaptations of psychoanalytic therapy to the treatment of delinquents. The extent of this change is reflected

in the contributions emanating from various countries such as England, Holland, India, and especially the United States. Most of the articles are on a high level, with particular emphasis on problems of values, ethics, and social responsibility.

Any selection of specific papers for comment may reflect this reviewer's personal bias. Notwithstanding, attention might be drawn to K. R. Eissler's *Some Problems of Delinquency,* in which basic issues are discussed; to Anna Freud's *Certain Types and Stages of Social Delinquency,* for its simplicity, clarity, and penetration; and to Willie Hoffer's *Deceiving the Deceiver,* in which dynamic principles are elaborated.

Many questions that might lead to problems of research are suggested by the writers. A theme that runs throughout the book is the need for further study of early psychological development to discover the roots of delinquency. Cultural, environmental factors, as well as psychological, are favored as predisposing to delinquency. One or two papers—for example, Jeanne Lampl-de Groot's *Neurotics, Delinquents, and Ideal-formation*—consider the problem of the choice of neurosis, which it would seem is worthy of further study. Freud's basic concept of a complementary series of constitution, early experiences, and trauma might have been more seriously considered.

The editors of this work deserve much credit, however, for assembling so many diverse points of view about delinquency, and the book should be a source of stimulus for any worker in the field.

JOSEPH J. MICHAELS.

Boston, Massachusetts.

FORTY-FIVE IN THE FAMILY: THE STORY OF A HOME FOR CHILDREN. By Eva Burmeister. New York: Columbia University Press, 1949. 248 p.

Miss Burmeister has written a warm, human story of a children's institution. It is readable, humorous, serious, and delightful. Any one who has ever worked in a children's home, or who has lived in a large family, will recognize that this is authentic—written from real life and experience with real children, in a real building, with real house-mothers, cooks, and pets. It is written by a person who has experienced frustration and failure as well as satisfaction and success. It is a cheerful, heart-warming book because one feels the attitude of kindliness and understanding that the author's sense of humor makes possible in spite of the ever-threatening chaos that children, pets, and staff changes create.

What Miss Burmeister has to say of the Lakeside Children's

Center, in Milwaukee, Wisconsin, has general application to the institutional care of children. Physical problems of housing, housekeeping, feeding, and daily routine are discussed from the practical point of view and in the light of how they impinge on the children whose care and welfare is the concern and function of the institution. Ingenuity and imagination transform an institution into a home where children not only live, but grow, with all the storms and set-backs and achievements that human growth entails. Work, school, play, and vacations through the changing seasons are described. One sees the children as individual people, bringing to the institution the constellations of complex disturbances that have been their past. The goal that Miss Burmeister clearly recognizes should dominate the residential home is adjustment to a future in the community outside of the institution, rather than smooth-functioning conformity.

Miss Burmeister discusses intake problems and the appropriate selection of children for group care. "Jane Comes to Stay" is the heading under which she describes the admission process. The routine program and activities that serve as a background for the human relationships that are the treatment process come alive as one sees Danny, Judy, Ellen, or Jonathan participating in them. Length of stay and preparation for discharge receive deserved attention. It is recognized that institution children not only have pasts, immediate needs, and futures—they also have families or outside contacts. The relationship of the child to his own family remnants and of his family to the institution is discussed.

Many small residential homes are not fortunate enough to have the services of a trained case-worker. If this book achieves the circulation it deserves among board members of children's institutions, it may well be that this lack will be corrected. Staff workers in children's institutions and case-workers can learn from Miss Burmeister's book of the problems that confront each other. One hopes that the result will be increased mutual understanding and respect.

Professionally trained workers may say that the book says nothing that they did not know before about a child's emotional needs. They will, however, be glad to find psychological truths expressed in simple, warm, human terms. They will be glad to see that an old-fashioned, regimented children's institution can, in the hands of enlightened personnel, evolve into a real home for children.

FLORENCE CLOTHIER.

New England Home for Little Wanderers,
Boston, Massachusetts.

FOSTERING MENTAL HEALTH IN OUR SCHOOLS. (1950 Yearbook of the Association for Supervision and Curriculum Development.) Washington, D. C.: The National Education Association, 1950. 320 p.

The concern of the school for the mental health of the child has reflected other developments in the mental-hygiene movement. Varying emphasis has been given to the treatment of "problem" children, the early detection of emotional disturbance, study of the individual child and his needs, understanding of the causes of behavior, and courses in human relations and "effective living." Eighteen educators, most of them from the University of Chicago, have taken the logical next step and in this yearbook have set down proposals for rebuilding "a system of education which will maximize the healthy growth and integration of emotional, social, and intellectual aspects of each child—a system of education which will foster mental health."

This book, with separate chapters by authorities on the respective subjects, is undoubtedly one of the most important documents to appear in its field, with implications both for education and for mental health. It proceeds on the premise that "the conditions of good mental health require that the school create a situation for *all-day-long* where there is a healthy emotional climate—where good human relations between child and child, and between teacher and child can flourish .... providing many more experiences that relate to spontaneous and developmental interests of children .... providing the conditions necessary for good mental health."

From this point of view, the authors examine traditional ideas of what children should be taught and how they can be made to learn. They arrive at conclusions that point to revisions of curriculum and teaching methods in terms of the long-range goal of integrated growth, as well as of the specific learnings—the skills, knowledge, and experiences—that the child needs at each successive stage of his development.

The concept of "developmental tasks" they believe to be "the most important single consideration in building a good curriculum and in formulating school policies and procedures." From studies in the field of human behavior, taking into account the sociological, psychological, and biological aspects of the child, they derive the tasks appropriate to each of five stages of development, and list them in ten "categories of behavior." These are offered as a basis for curriculum planning, with the conviction that "only to the extent that the curriculum meets the developmental needs of children can it be a curriculum which fosters the mental health of children."

In addition, the committee gives particular attention to several of the factors that determine how the child will grow and act. One of

these is how the child feels about himself and about others. Numerous real-life episodes throughout the text show how the teacher can come to understand the child as a *feeling-thinking-acting* person through her own observations, and through anecdotal records, socio-metric groupings, and parent conferences. There are also dramatic illustrations of those situations and experiences within the classroom that give the child the opportunity to express and to deal with his feelings through "make-believe," stories, drawings, socio-drama, class discussions, and informal talks.

Another factor that has been given too little recognition is what the child brings to school from his family and social-group situation. The studies of Havighurst, Davis, and others point up the significance of the finding that the majority of children in our schools come from minority racial and ethnic groups or from socio-economic groups other than the middle class. For them a conflict arises from the differences between what they have experienced and the "pattern of standards, behavior and expectation" held up by the school. The effect of such cultural and social background differences upon the child's self-respect and ability to learn must be taken into consideration if what is being taught is to be made meaningful and acceptable to him.

How to make the child want to learn what he needs to learn has always been a central problem of pedagogy. It is observed that "many children begin to dislike school by the time they reach the third grade, and that they never recapture their earlier enthusiasm." A repressive classroom atmosphere takes its toll in stifling the child's natural interest in learning. The conventional techniques of motivation through competition, achievement, punishment, rewards, are found to be less effective than utilization of the child's spontaneous interests, his desire for participation and belonging, his identification with values and the ideal represented by the teacher.

All of this, of course, raises questions as to the training and personality qualifications of the teacher that lie beyond the scope of this volume. It is, however, noted that the teacher's mental health "may well be the primary factor in the school's contribution to the wholesome development of children." Modifications of the curriculum of teacher-training institutions are seen as of crucial importance in order that they may "offer preparation in the techniques of teaching children" as well as subject matter.

These recommendations for fostering mental health in the school represent an integration of documented research findings and educational experience, psychological insight, and appreciation of the potentialities of children. The assumptions and procedures outlined have been found to work well in nursery education, in the laboratory

school, and in the more progressive school systems. As parents, teachers, administrators, and community leaders ask themselves, "What kinds of experience does each child need to have as a thinking-feeling-doing person to take his next steps in a democratic society?" such changes as will foster mental health in all our schools for all our children may be seen as inevitable.

ZITHA R. TURITZ.

Division of Education, National Association for Mental Health.

CHILDREN IN CONFLICT. TWELVE YEARS OF PSYCHOANALYTIC PRACTICE. By Madeleine L. Rambert. New York: International Universities Press, 1949. 314 p.

This book, which has a brief preface by Jean Piaget, was translated by Yvette Moxley. It is a welcome addition to the literature on child analysis. It should also be useful to people who are doing psychotherapy with children.

Since Mlle. Rambert prefers puppets to other play material in her own psychoanalytic work, naturally parts of her book deal with this method. But she also discusses children's drawings and dreams, infantile sexuality, family relationships and the child's problems, transference, and other subjects of general interest. The book is divided into three parts: Part I, which deals with examinations preliminary to accepting a child for analysis; Part II, on treatment methods and techniques; Part III, on problems of practice and theory.

In the first part, Mlle. Rambert emphasizes that before acceptance of a child for analysis, there should be medical examinations to rule out the possibility of physical illness and psychological examinations to exclude the possibility of mental retardation. She points out that only if a child is in good health and is intelligent and if his family understands the need for psychoanalytic treatment, should it be undertaken. In the reviewer's opinion, these are prerequisites for accepting a child for either psychoanalysis or psychotherapy.

There is a very interesting description of traumatic experiences as determined not only by actual events, but by the child's state of mind at the time an event occurred. Mlle. Rambert suggests, for example, that reprimands or punishments that have very little bad effect on a child ordinarily, may be traumatic at a time when the child chances to be in an unusually sensitive mood. She mentions certain situations that are frequently traumatic, such as the birth of another child; prolonged absence, illness, or death of a parent; divorce and remarriage; and so on. She comments, however, that any operation the

child may undergo is potentially the most dangerous experience, implying that this is even more likely to disturb the child than the loss of a parent through death or divorce. It hardly seems possible that this implication was intended and it may well be that a lack of clarity in writing obscures the author's real opinion. Certainly Anna Freud's work with English children and child-guidance work in this country indicate that loss of a parent is one of the most traumatic events for a child. Indeed it may be quite as much because the child usually is separated from the parents when undergoing an operation as because of the operation itself that a child suffers from the experience.

Part II of the book is largely devoted to an exposition of child analysis, including the first sessions, the stage of conscious realization of emotional conflicts and their liquidation, and the period of reëducation during the ending phase of the treatment. Part II also contains a chapter on the analysis of children over ten years of age and a chapter that presents a case history. There are also a great many excerpts from case material used for purposes of illustration in other chapters, in addition to this longer case history.

Part III begins with a chapter on some of the common problems in infantile sexual development. This chapter is followed by one on transference. Mlle. Rambert indicates that young children often do not make a transference directly onto the analyst, but are more likely to project their positive and negative feelings into play with puppets, drawings, or other play activities. She apparently regards this kind of projection of emotional conflicts as a form of transference; thus she uses the term with a somewhat broader meaning than is usual.

The last section of the chapter on transference is a discussion of counter-transference in child analysis as differing somewhat from counter-transference in adult analysis. The author believes that in addition to objectivity in child analysis, there must be a degree of interest and even affection that would not be suitable if the patient were an adult. Mlle. Rambert devotes some space to an effort to describe the kind of affection a child analyst may have for a patient, which naturally cannot be the same as a mother's love for a child. It seems to the reviewer that she succeeds better in saying what the analyst's love for the child should not be than what it should be. There is no disagreement, however, with her statement that the analyst should not expect any return from the child in the way of securing his love for personal satisfaction, but should be able to handle the transference so that the love that may have been released will turn toward the parents. The analyst's source of satisfaction,

of course, is in seeing the child cured of his neurosis or freed from obstacles to his development and better able to realize his potentialities for growth and adjustment.

In the chapter on dreams, there is the statement (p. 161) that children are incapable of forming any associations to their dreams. It is the reviewer's experience that the majority of children either do not recall dreams or do not associate to the dreams they report, but there is the occasional patient who can produce associations if these are asked for in a manner suitable to a child. In an article on the use of dreams in psychiatric work with children,[1] Dr. Lippman describes associations to dreams that he obtained from some of his child patients. Thus both Dr. Lippman's and the reviewer's experience would indicate that Mlle. Rambert's statement concerning the incapacity of the child to associate to dreams is too extreme and should be modified.

Mlle. Rambert ends her book with a tempered judgment on the effectiveness of child analysis, with which we can most heartily agree. As she states, analysis may help the child to more comfortable daily living and better emotional development, but it cannot insure him against the possibility of neurosis for the rest of his life.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

[1] In *The Psychoanalytic Study of the Child*, Vol. I. New York: International Universities Press, 1945.

NOTES AND COMMENTS

1950's Outstanding Aide to the Mentally Retarded

Chosen by a national panel of judges from more than 5,000 participants in a competition sponsored by the National Association for Mental Health, Miss Eileen Bunyan, an aide in the Children's Colony of Monson State Hospital, at Palmer, Massachusetts, has received the award for 1950's outstanding aide to the mentally retarded.

The award, consisting of $500.00 and a certificate testifying to her distinction, was presented to Miss Bunyan last January, in a public ceremony at Palmer, by Oren Root, President of the National Association for Mental Health. In a citation read at the presentation, Mr. Root spoke of Miss Bunyan's "superb rôle in opening doors to the outside world, awakening the interest of the people of Palmer in these previously forgotten children, and improving immeasurably the working atmosphere within the colony." He said further that this award, presented this year for the first time and destined to be an annual event, was made by the National Association for Mental Health in order to "focus public opinion on the needs of the 1,500,000 mentally retarded people in our country and to recognize the efforts of progressive aides, who, in day-to-day work with their patients, are helping to improve the quality of care and training throughout the country."

Dr. Roger G. Osterfeld, Superintendent of Monson State Hospital, explaining why Miss Bunyan had been nominated by the hospital staff as their candidate for the award, said that she had come to the training institution five years ago to find a group of children who, following a forty-year tradition, lived secluded and restrained lives. Because of frequent fights amongst themselves and with their attendants, their slovenly personal habits, their fear of meeting strangers, and their attempts to escape, the children were continually locked indoors, had no visitors, and were put to bed immediately after dinner.

Miss Bunyan enlisted the interest of the institutional staff in developing new activities for the children. She organized outdoor games, accompanied the youngsters on overland hikes, and formed troups of Boy and Girl Scouts. As fights and attempts to escape became less frequent, the children were allowed more and more freedom around the colony and the grounds. Garden and household-work details were organized, the children helped in the cooking and cleaning at the school, and later glee clubs and dramatic groups were formed.

Miss Bunyan drew on her previous dramatic experience as a W.P.A. theater director to write and direct stage plays for the children, which were produced in Palmer and in nearby towns. In all, more than 6,000 people have seen the children's production in outside auditoriums. Local appreciation of the changed atmosphere in the children's colony is evident in gifts of radios and phonographs, pianos and wire recorders, movie cameras and projectors, and even a wading pool which is used for skating in the winter.

In addition to the main award, five awards of $50.00 each were given to aides employed in institutions in New Jersey, Delaware, Illinois, California, and Oregon; and nineteen aides received honorable mention.

The judges who selected the recipients of the awards were Pearl Buck, novelist; Albert Deutsch, mental-health news columnist; Alan Sampson, President of the National Association of Parents and Friends of the Retarded; Richard H. Hungerford, President of the American Association on Mental Deficiency; and Mildred Thomson, head of the Minnesota Bureau for Mentally Deficient and Epileptic.

Twenty-Eighth Annual Meeting of the American Orthopsychiatric Association

The American Orthopsychiatric Association held its Twenty-eighth Annual Meeting at the Book-Cadillac Hotel, Detroit, Michigan, February 22–27. At the general session which opened the meetings, H. Whitman Newell, Clinical Director of the Psychiatric Clinic, of Baltimore, presented the Presidential Address, on the theme, "Fulfilling Our Purposes." Papers were presented also by Talcott Parsons, of Harvard University, who spoke on "Illness and the Rôle of the Physician in the Light of Sociological Theory," and by Lawrence E. Cole, of the Department of Psychology, Oberlin College, whose subject was "The Right to Believe."

The sessions and discussions that followed covered as usual a wide field, ranging from such broad subjects as "The Road to Industrial Peace," "Orthopsychiatry in Education," and "Social and Cultural Factors in Mental Health" to clinical presentations of individual cases. One session was devoted to a showing of recent mental-health films. The program included also a cocktail party and a dance.

The meeting was attended by over 1,300 people, representing 40 states, the District of Columbia, and Canada. The 1952 meeting will be held in Atlantic City, February 25, 26, and 27.

The officers of the association for the coming year are: president, James M. Cunningham, M.D.; president-elect, Morris Krugman, Ph.D.; secretary, Exie Welsch, M.D.; and treasurer, Simon H. Tulchin.

Eighth Annual Conference of the American Group Therapy Association

The American Group Therapy Association held its Enghth Annual Conference at the Hotel New Yorker, New York City, on Friday, January 26 and Saturday, January 27, 1951.

The Friday evening session dealt with the wider implications of group psychotherapy. Current trends were discussed by S. R. Slavson; psychoanalytic concepts by Dr. Florence Powdermaker and Dr. Nathan Ackerman; and group psychotherapy in the light of social anthropology by Dr. Margaret Mead and Dr. Warner Muensterberger.

The Saturday morning session included three round tables, dealing, respectively, with group psychotherapy in mental hospitals, in general hospitals, and in correctional institutions and agencies. Among the participants were Dr. Nathaniel J. Breckir, Dr. Benjamin Simon, Dr. James Lawton, Dr. Nathan S. Kline, Dr. Samuel B. Hadden, Dr. Jerome Frank, Dr. Sara Dubo, Dr. Jerome Styrt, Dr. Joseph H. Pratt, Lloyd W. McCorkle, Dr. Joseph Abrahams, Dr. James Fidler, and Dr. James Thorpe.

At the Saturday luncheon, at which Margaret Naumburg presided, Dr. James H. Pratt, Dr. M. Ralph Kaufman, and Dr. Wilfred C. Hulse delivered addresses.

At the Saturday afternoon session, a case treated in activity and interview group psychotherapy at the Community Service Society was presented by Dr. Hanna Grunwald, group therapist; Dorothy Headley, case-worker; Dr. Rutherford B. Stevens, psychiatrist; and S. R. Slavson, consultant in group therapy. Among the discussants were Dr. Peter B. Neubauer and Dr. Jean A. Thompson. The chairman of the session was Dr. Joseph J. Geller.

Fourth International Congress on Mental Hygiene

The Fourth International Congress on Mental Health will be held in Mexico City, D. F., December 11 through 19, 1951. This will be the first congress to meet in the Western Hemisphere in the last twenty-one years. Members of state and local mental-hygiene societies, state mental-health authorities, psychiatrists, psychiatric nurses and social workers, psychologists, and health educators, responsible for interpretation of mental-health principles, will find this announcement of special interest. Prior to the congress, the Executive Board and the Inter-Professional Advisory Committee of the World Federation for Mental Health will gather for three days to plan the following year's work for the interpretation and implementation of the mental-hygiene movement on an international level.

International Association for Child Psychiatry to Participate in Mexico City Congress

The International Association for Child Psychiatry announces its participation in the Fourth International Congress on Mental Health to be held in Mexico City, December 11–19, 1951. It will be responsible for one plenary session on "Mental Health in Education," and in addition will organize special work groups. The number and nature of these will depend upon the number of participants and their fields of special interest. Any suggestions for fields that might be of interest in the work groups will be welcomed by the committee arranging for these. Please send them to Dr. A. Z. Barhash, Secretary-General, International Association for Child Psychiatry, 1790 Broadway, New York 19, N. Y.

Mental-Health Experts Fly to Dublin to Plan World Conference

Leading American experts on national and international psychological and mental-health problems flew to Dublin in March for a two-week meeting with experts from other countries to further plans for the Fourth International Congress on Mental Health, to be held in Mexico City on December 11–19, 1951. Included in the party were Dr. George S. Stevenson, former president of the American Psychiatric Association and present medical director of the National Association for Mental Health; Dr. Margaret Mead, well known anthropologist and author of *Male and Female;* Dr. Otto Klineberg, international specialist and consultant on race and Negro problems, and professor of psychology at Columbia University; Dr. Bingham Dai, Chinese-born professor of psychiatry at Duke University, and psychoanalyst in the Duke psychiatric clinic; and Dr. Nina Ridenour, writer on parent-child problems and educational director of the National Association for Mental Health.

International Congress for Psychotherapeutics To be Held in Holland

Under the auspices of the Dutch Society for Psychotherapeutics, an International Congress for Psychotherapeutics will be held at Leiden-Oegstgeest, Holland, from the 5th to the 8th of September inclusive. The subject of the congress will be "The Affective Contact." Six plenary sessions will be held, each lasting three-quarters of an hour, with no discussions to follow. They will treat, respectively, of: (1) the psychological-biological aspect; (2) the social aspect; (3) the phenomenological aspect; (4) the psychoanalytical aspect; (5) the personal realization in psychotherapy; and (6) the significance

of the structure of the personality in the affective contact. In addition, there will be three section meetings, dealing, respectively, with infant psychotherapy, group psychotherapy, and psychosomatic therapy. At these section meetings there will be an opportunity for foreign speakers to present lectures.

For further information, write to A. H. Fortanier, M.D., Psychiatric Clinic of the University of Leiden, Leiden, Holland.

Dutch Federation for Mental Health Offers Mental-Health Tours

The Dutch Federation for Mental Health is organizing two mental-health tours for foreign workers in the field of mental health who would like to include a visit to Holland in their summer plans. One tour is designed for those who are especially interested in the institutional and social care of mental patients, and the other for those who are working with problem children. Each tour would cover six days and would include not only visits to institutions, but some sightseeing of places off the beaten track of tourist travel. Any one interested in learning more about these tours should write as soon as possible to the Nationale Federatie voor de Geestelijke Volksgezondheid, Prinsengracht 717, Amsterdam, Holland.

Conditions Affecting Mental Health of the Aged to be Subject of Research Program

An intensive research program to discover what conditions are associated with mental disease among the aged was inaugurated last January by the New York State Mental Health Commission in coöperation with the Council on Aging of the Council of Social Agencies in Syracuse. The project was launched at a dinner which climaxed a three-day conference. The dinner was attended by representatives of the five state departments of the mental-health commission, the governing board of the council, and key community people in the field. Benjamin Shove, President of the Council of Social Agencies, presided.

Dr. Ernest M. Gruenberg, Executive Director of the New York State Mental Health Commission, expressed the hope that the study would reveal to what extent the provision of social and other community services may prevent mental breakdown among the elderly. The Syracuse research unit of the commission will concentrate on studying the experiences of older people in Onondaga County, and the factors that influence their mental health. This will include a planned experimental program of services and an evaluation of its effect on the incidence of mental disease among the participating group. The

project will also include a statistical study of the influence of social and economic factors on the mental health of the aged.

A survey of local agencies has been started by the Council on Aging of the Council of Social Agencies to determine the extent of their services and where they need strengthening. "The Mental Health Commission does not wish to displace or substitute for local agencies," Dr. Gruenberg declared, "but is anxious to coöperate, assist, and supplement them in the development of their programs and especially in evaluating their effects on mental health."

The Syracuse research project, of which this study is the first phase, is a pilot experiment to obtain authoritative information that can be used to formulate a master mental-health plan for communities throughout the state.

Dr. Gruenberg pointed out that geriatric psychiatry has been selected for research because of the magnitude of the problem of mental disorders of the aged. "It is the only group of committable disorders for which the rates of hospitalization are known to have increased during the past century," he said. "On the basis of this increase and the additional fact that the proportion of older people in the general population is increasing, we know that there will be a corresponding increase in the absolute magnitude of mental disorder of the aged."

The following panel of authorities will act as consultants to the project: Dr. F. C. Redlich, professor of psychiatry, Yale University; Professor A. B. Hollingshead, of the department of sociology, Yale University; Dr. John Claussen, social scientist, National Institute of Mental Health; Dr. Alexander Leighton, professor of industrial sociology, Cornell University; and Dr. F. C. Richardson, of Harvard University.

The Mental Health Commission, created by the legislature in 1949, is headed by Dr. Newton Bigelow, New York State Commissioner of Mental Hygiene, and includes state commissioners of social welfare, health, correction, and education. Its major objectives are: (1) education of psychiatric specialists, (2) development of psychiatric services in the community, and (3) research in community mental health. The commission will integrate the activities of the five state departments with those of all local agencies in the formulation of a master plan for community mental health.

Fellowships Offered Psychiatric Practitioners

The New York State School of Industrial and Labor Relations at Cornell University, through a grant from the Carnegie Corporation, is offering two-year fellowships in industrial psychiatry. Candidates for the fellowship must have had two years' approved training in general psychiatry and must be interested in contributing to the

development of preventive and social psychiatry. Approximately eight months of on-campus work and sixteen months as an interne in industry comprise the training period. Stipends of from $4,000 to $5,000 depend upon individual qualifications. Details may be obtained from the College of Arts and Sciences at Cornell University, Ithaca, New York.

Functions and Training of the Mental-Health Nurse

The following statement on the functions and training of the mental-health nurse has been approved by the National Advisory Mental Health Council:

> "To assist in planning the general public-health nursing program in order that adequate emphasis may be given to a special field.
>
> "To serve in a liaison capacity between the public-health nursing services and a special division of the health department.
>
> "To coördinate a special service with the programs of other agencies.
>
> "To participate in the supervisory and staff education programs of the agency in coöperation with other professional personnel.
>
> "To help establish criteria for the evaluation of nursing programs in regard to a special field.
>
> "To assist in improving clinic facilities by making suggestions in regard to technique, record-keeping, follow-up, case-finding, and use of educational opportunities in a clinic.
>
> "To assist in the conduct of studies and surveys with regard to special services.
>
> "To analyze, appraise, and advise regarding policies, techniques, and procedures.
>
> "To assist in the preparation of manuals, reports, record forms, and factual material in a special field.
>
> "To keep informed of developments in a special field and interpret them as related to nursing.
>
> "To stimulate interest in nursing education in a special field on the basic and graduate level.
>
> "To perform related work as assigned.
>
> "*Recommended preparation:*
>
> "1. Graduation from an approved school of nursing with a program that includes or is supplemented by instruction and experience in the application of principles of mental health, the prevention of mental illness, and the nursing care of the mentally ill.
>
> "2. Completion of an approved program of study in public-health nursing in an accredited college or university.
>
> "3. Completion of an approved advanced program of a year or more in mental-health nursing with academic credit toward a Master's degree.
>
> "*Recommended experience:*
>
> "1. Evidence of satisfactory supervisory experience, at least two years of which should have been in a generalized public-health nursing agency.
>
> "2. One or more years' experience as a mental-health nurse in a community mental-health clinic, or equivalent experience in a public-health nursing agency subsequent to the program of advanced study."

News of Mental-Hygiene Societies

Compiled by

Marjorie H. Frank

State and Local Organization Division, National Association for Mental Health

Delaware

The Delaware State Society for Mental Hygiene has written us stating:

> "The National Institute of Mental Health has been much interested in our mental-hygiene programs in schools, and last year made a grant of funds to our society, so that we could hold a human-relations workshop to train selected educators from other states. Outstanding educators came to this workshop from sixteen different states.
>
> "Most of the workshop members were sent by state mental-hygiene authorities, by mental-hygiene societies, or by state, county, or city school departments. The Cleveland Mental Hygiene Association, the Massachusetts Society for Mental Hygiene, and the Charlottesville Mental Hygiene Society sent staff members. A number of mental-hygiene societies encouraged school systems and state mental-health authorities to defray the expenses of educators to the workshop.
>
> "Without exception, those who attended our workshop last May felt that they gained a great deal from this experience of meeting with people from many states who are successfully introducing positive mental-hygiene principles into classes of normal boys and girls in public schools. Because of the great success of our first human-relations workshop, we are holding a similar workshop the first week in April at the University of Delaware."

Florida

Mrs. Marjorie Frank, of the State and Local Organization Division, the National Association for Mental Health, attended the second board meeting of the Florida Mental Health Society in January, at which the board decided upon a six-point legislative program for 1951. This program would cover necessary appropriations for the operation of the Florida State Hospital and the Florida Farm Colony, with continued emphasis on the economy of treating mental illness by providing additional psychiatric staff. The amounts the society is backing are the amounts requested by the superintendents.

The other five points of the program are: a bill to provide additional funds so that hours and wages of employees in mental institutions will compare favorably with similar jobs in other state institutions; a bill to provide $2,163,000 for much needed facilities in the farm colony for white and Negro children (there are no facilities in Florida for Negroes now); revision of commitment laws (1) to make

provision for paying doctors who attend patients confined to jails and other facilities while awaiting transfer to state mental institutions, and (2) to provide for voluntary commitment and the commitment of patients on medical certification to general hospitals with psychiatric wards and private institutions; a $100,000 a year appropriation for the mental-health program of the Florida State Board of Health, to provide child-guidance clinics and educational programs (this will be matched by National Mental Health Act funds); and a bill to provide for a committee to study and plan a decentralized state-hospital program—hospitals to be in or near population centers—carrying an appropriation of $200,000 to provide for surveying, locating, and drawing plans for two 1,000-bed hospitals. One of these hospitals is to be located in South Florida, the other in the Tampa Bay area. Provisions were included for constructing 500 beds in each location as a beginning. The study is to be made by an architect to be employed by the Board of Commissioners of State Institutions for Mental Institutions or the Florida State Improvement Commission.

The budget of the farm colony was reconsidered after a special hearing arranged by the Florida Mental Health Society, and the budget committee approved a $50,000 increase.

At the January meeting, the six local Florida mental-hygiene societies pledged 50¢ of each of their membership fees to the state society. Definite relationships between the locals and the newly formed state society will be worked out by the state society's committee on constitution and by-laws and will be presented at the society's first annual meeting, to be held probably in November, 1951.

The Mental Health Society of Southeastern Florida has focused most of its attention at this time on the legislative program. Mrs. Richard Stover, chairman of the state society's legislative committee, is a resident of Miami, and the local society is giving her as much support as possible.

Georgia

Mrs. Frank reports from her field visit that on January 10, 1951, Georgia officially organized a state society. Representatives from four separate parts of the state attended. Mrs. Robert Young, of Savannah, was elected president, and Mrs. Clifford Street, of Atlanta, vice president. Those present included educators, public-health officials, psychiatrists, general practitioners, lawyers, and the president of the Savannah local society, who is the publisher of a leading newspaper there. The society is planning immediately to appoint a permanent nominating committee, finance committee, legislative committee, field-study committee, and a committee on affiliation which will

work with the national organization. The two active local societies, those of Savannah and of Atlanta, are planning to contribute to the state society's budget, and Macon is now planning to organize a local society.

Hawaii

We have received a report of a health survey made in Hawaii in 1950 under the auspices of the Oahu Health Council, with the assistance of the department of health and other official and voluntary agencies concerned actively with public health. It was noted that there were inadequate resources for adult mental hygiene, in contrast with the essential service (primarily in behalf of children and for the prevention of juvenile delinquency) of the department of health, and the progressive treatment services of the department of institutions.

A number of proposals for long-term development were offered for consideration, one of them being that the Community Chest and other private support for the Mental Hygiene Society of Hawaii be continued and raised to a higher level. Other recommendations were that more accessible and extensive mental-health outpatient clinics and agency-consulting facilities be provided both for adults and for children, facilities for the latter being so placed that their services will be integrated with the child's daily educational and recreational life; that increased attention be given to gaps in child-guidance services; and that the services of the psychological clinic be reallocated in such a way as to meet the community needs more fully. While the psychological clinic has rendered valuable and essential services, its continuance as a separate unit is questioned; consideration should be given to reorganization in such a way as to strengthen at the same time the meager psychological services of the department of health and of the mental hospitals.

In this report it was also stated that the only major health agency in the Community Chest is the mental-hygiene society, with an enlarged allotment for 1951 amounting to $9,950.

Illinois

The *Mental Health Bulletin* of the Illinois Society for Mental Hygiene, in its November-December, 1950, issue, reports in detail on a workshop held in Northbrook, Illinois, devoted to the consideration of the emotional needs of children. The newsletter describes the planning and orientation, the preparation and participation, and the content and evaluation of this workshop. We feel that this description will be of value to any society planning a similar project.

The Illinois society informs us that the newly organized psychiatric-nurses section, in consultation with the society, is planning a two-day institute to consider the professional responsibility of the nurse as a member of the medical team.

The society still has available in limited quantity a carefully documented Directory of Psychiatric Facilities in Illinois, compiled and distributed as a community service for agencies and individuals who require knowledge of such resources.

The state society, along with its affiliate local societies, is planning a mental-health conference for April 17. Governor Adlai Stevenson will address the conference on the state mental-health program. Representatives of affiliated societies will describe local contributions to the state program.

In its February newsletter, the society reports that the twelfth group of occupational and recreational therapists has just been oriented to the two months' training course offered by Manteno State Hospital since November, 1948. Currently, there are five recreational and nine occupational therapists enrolled. Preceding this group, 108 students completed the course. These included 50 occupational therapists, 57 recreational therapists, an industrial therapist, and a bibliotherapist. Mary Haggerty, of New York, has been assigned to the music department and will assume responsibility for the orientation of trainees participating in musical therapy. Workers from other state hospitals are encouraged to take advantage of the in-service training program sponsored by the hospital at Manteno.

Indiana

The Indiana Mental Hygiene Society was host at a two-day meeting with representatives from Ohio, Kentucky, Illinois, Michigan, Minnesota, Wisconsin, and Iowa. Mr. Oren Root, Dr. George Stevenson, and Miss Marian McBee, of the National Association for Mental Health, also attended the meeting. This was the first regional meeting aimed at forming closer ties between the national organization and state and local mental-hygiene societies.

The Indiana Society has 9 active chapters and 6 more in process of formation.

The state society is at present conducting classes for teachers in public schools at Purdue University extension, and in conjunction with the Central District Nurses Association, has just conducted an institute for nurses who wish information in the field of psychiatry.

Joining with the Indianapolis Church Federation and the Ministerial Association, the state society held a mental-hygiene institute for ministers in March.

The society is actively engaged in backing legislation in the current session of the legislature and feels that the results of an intensive study by the society's legislative committee are showing up in measures proposed and bills being passed.

The Indiana Society plans to coöperative with the state and county civil-defense organizations by organizing and training speakers on "Mental Health and the Prevention of Panic," "Safeguarding Children's Feelings of Security," "Building Morale for Coping with Military Attacks," and other subjects, as part of its overall program of public education.

Some of the Indiana local societies have started programs of service to the state psychiatric hospitals. These mostly consist in providing parties and contributing gifts, such as phonographs, records, television sets, and personal gifts to patients, particularly those who have received no visitors in the past year. One of the projects mentioned is the tuning of all the pianos in the hospitals.

Iowa

We note in *Iowa Mental Health*, published by the Iowa Mental Health Authority, that under the presidency of Mrs. Gordon DeLay, of Cedar Rapids, the state society is promoting a mental-hygiene program in which every one can participate. An open-forum meeting was held in February, on the objectives for 1951, and Dr. William Menninger spoke on "Psychiatry for Everyday Needs."

The Polk County and Scott County mental-hygiene chapters have been active with regular meetings and are stimulating interest in needed psychiatric hospital and clinic facilities.

Maryland

The Mental Hygiene Society of Maryland has submitted an excellent report of its 1950 Christmas Project for state hospitals. This report describes the number of presents selected, wrapped, and delivered by the society's volunteers, and sets forth in detail the types of present given to the various types of patient, both in the hospital and in the institution for mentally deficient. This shows what great care there should be in the selection of gifts, so that they may be of the most benefit to the patients. The report also tells how newspapers, radio, and TV stations coöperated and the type of response from these media, which the society claims was overwhelming.

The society reports that several organizations have voted to make the Christmas Project a permanent part of their yearly activities,

and many groups are telephoning for appointments to discuss the possibility of assuming a more active project in the hospitals on an around-the-calendar basis.

The society and the Baltimore-area Girl Scouts Council have made plans jointly to send handiwork supplies to patients. According to current budget figures, the sum appropriated by the four mental hospitals for all educational, vocational, and recreational supplies averages only 84 cents per patient per year, whereas a local private nursery-school director estimates that her school spends approximately 40 dollars per child per year. The Baltimore-area Girl Scouts Council, as its 1951 project, will attempt to obtain from 1,000 to 2,500 cartons of supplies—enough to provide a continuing occupational-therapy experience for all patients who might profit by it. The society has prepared 12,000 flyers to be distributed among the Scouts and the more than 2,000 adults in the local Scout movement. The flyers suggest the types of material most urgently needed.

An impressive demonstration of the value of public interest in mental hospitals occurred during January, when the Baltimore Tuberculosis Aid Society formally dedicated the furnishings they had provided for the dining room and the recreation room for tuberculous male patients at Crownsville. The group's contributions to these quarters are both practical and attractive—dining-room tables and chairs, a radio-victrola, a television set, pictures for the walls, potted plants, drapes at the windows. They were guided by the standards of the American Psychiatric Association, as well as by their own years of experience in tuberculosis sanatoria.

In addition to their service to the Crownsville patients, the Baltimore Tuberculosis Aid Society has made substantial contributions to the comfort and welfare of tuberculosis patients at Springfield, and is planning to undertake a project at Rosewood.

Fifteen newly trained volunteers started work during January at Rosewood State Training School, under the joint auspices of the society and the Baltimore section of the Council of Jewish Women. The group, recruited by Mrs. Maxwell Behrend, council chairman, were interviewed by Mrs. Dorothea Wisman, the society's director of service to the mental hospitals. They represent a birthday celebration for a distinguished project that was begun in January, 1950.

An introduction to the feebleminded, their problems and their potential, was the principal feature of their 12-hour training course. The volunteers also made a field trip to P. S. No. 48, to observe the special class taught by Mrs. Arthur Lichtenstein. Additional orientation to their work is being planned at the institution by Mrs. A. G. DuMez, the institution's coördinator of volunteer activities.

The council volunteers work at Rosewood in daily teams, taking the children for walks, teaching them to ride bicycles and to roller skate, visiting patients in the hospital, and meeting the special needs of selected children such as those who are blind or crippled.

The society's second annual institute for the clergy of Baltimore, to be held in April at Spring Grove State Hospital, is open to clergymen of all denominations. At a recent committee meeting, it was decided that the institute should cover six sessions, the first of which will include an extensive hospital tour conducted by Dr. Isadore Tuerk, acting superintendent of the hospital. The four following sessions will be devoted, respectively, to discussions of the problems of alcoholism, delinquency, aging, and marital discord, each led by a psychiatrist who is a specialist in the particular field under discussion. The last session of the institute will be devoted to free discussion and a summary.

The clergy will have the opportunity of presenting problems to the speaker at the beginning of each session. Case histories will be used to illuminate the various problems under consideration.

The January, 1951, issue of the society's *Spotlight* has an account of a series of discussion meetings, led throughout by a psychiatrist, aimed at increasing the understanding between parents and adolescents. A series of seven consecutive evening weekly meetings were held, the first three open without registration to adults, the next three to adolescents, and the last, a joint meeting, to the two groups. At the close of the series, there was general agreement among the planning committee that educational work should be continued with the adolescent group, and the proposal was made that Dr. James S. May, Spring Grove psychiatrist, who participated in the seven meetings, should lead discussions in the secondary-school setting. Plans for this second experiment in East Baltimore are now being made.

Subcommittees of the society's public-education committee have agreed to write and produce a series of four TV shows to be released in the Baltimore area in April. The material will be slanted toward positive mental-health principles and will high-light what goes into rich and meaningful relationships, particularly in family living.

Massachusetts

The Massachusetts Society for Mental Hygiene helped to arrange the program for the presentation of the National Association for Mental Health's Award to the Outstanding Aide to the Mentally Retarded for 1950—Miss Eileen Bunyan, a member of the staff of the Monson State Hospital, near Springfield. Mr. Oren Root, president of the National Association, Dr. Roger G. Osterheld, superintendent

of the hospital, and other well-known Massachusetts Society members participated in this program.

Under the auspices of the Massachusetts Society, many school projects are being undertaken. Dr. Reuben Margolin, at a midwinter meeting of the general supervisors of public education of Massachusetts, offered a presentation of workshop techniques, particularly as a method of understanding emotional needs, which he illustrated by his account of experiences with the workshop for teachers conducted by Columbia University.

Orientation sessions for teachers in Leominster who were interested in the Delaware lessons were conducted during the month of February, and a similar plan has been worked out for Concord. A series of sessions on "Mental Hygiene and Teacher Training" have been booked for freshmen by the school consultant at Boston University College of Practical Arts and Letters, and for graduate students in psychiatric nursing at Boston University School of Nursing. The aim of these sessions is to provide orientation in this field, and especially to deepen interest in the significance of self-awareness.

A faculty conference was held with teachers from Holden to evaluate the findings from the human-relations lessons. A case presentation of a popular student as well as of a rejected student was presented for discussion.

During the week of January 28, the Mental Health Association of North Central Massachusetts—the new name of the society's affiliate—opened its drive for membership on an overall scale. It is hoped that from the 140,000 population of the 28 towns of the area, at least 10,000 members will be obtained.

In view of the interest being taken in the volunteer programs in mental hospitals, the society has asked Mrs. Alfreda G. Peterson, Director of Volunteers in the Foxboro State Hospital, for detailed news of the activities there. The group includes 53 volunteers from the towns around Foxboro and an increasing number of students from Wheaton College. Thanks to volunteer services, Mrs. Peterson says, the library is open daily, and the supply of books, newspapers, and magazines is replenished by gifts. Other activities regularly undertaken by volunteers on the wards include card parties, singing fests, and help with writing letters.

Among special events are the weekly Wednesday-night dances, in which volunteers from Wheaton College assist the occupational-therapy department of the hospital. Another weekly event to which all the patients look forward is the arrival of the entertainers from Seekonk, who include group singing in their program. Other interests are supplied by the Book Review Club, which meets Monday afternoons, and

an art class, which gets together two mornings a week. The monthly birthday parties, which provide a joint celebration for all those who were born in that month, are greatly enjoyed, especially the refreshments furnished by volunteers. Other activities in which volunteers have assisted are helping the kitchen staff with preparations for parties, making Christmas decorations, wrapping presents, and distributing Christmas cards for the use of patients.

The society is happy to announce that a similar program has now been started at the Danvers State Hospital. Any one who lives in that area who may be interested in this work should get into contact with the society or with Mrs. Wanda Walszak, Director of Volunteers at the Danvers Hospital.

Michigan

Miss Mary Bentley, Assistant Director of the Division on Community Clinics, National Association for Mental Health, was enthusiastic about the outstanding service given by the Michigan Society for Mental Hygiene in the operation of a placement service for clinical personnel at the February meeting of the American Orthopsychiatric Association in Detroit. The difficulty of locating qualified personnel for clinics has long been one of the main problems in the field, and because no placement agency covers all the professions, sometimes good people are lost. The National Association's Division on Community Clinics has tried in recent years to help people get in touch with one another at a few of the major conferences. This year, with the great help of the Michigan Society, this service was provided in an efficient manner.

A group of volunteers, under the supervision of Martha Yaekel, the assistant secretary of the society, began planning for this many months ahead of the meeting, and four volunteers at a time kept regular office hours, so that professional staff could register and clinic directors could obtain information as to available personnel. If applicants wished to talk things over in more detail, they were referred to the Detroit Branch of the American Association of Psychiatric Social Workers, to members of the staffs of well-established clinics who were present at the meeting, and to the staff of the National Association's clinic division.

Well over 100 people registered in two days, and these names are now being listed for wider distribution by the Division on Community Clinics. Many favorable comments and expressions of gratitude were received about this service from those attending the conference, with the suggestion that if possible this method be repeated every year as a regular part of the conference.

New Jersey

The Mental Hygiene Society of Union County reports that 1950 was a very active year for its community-education program. In the spring, three American Theatre Wing plays (*Temperate Zone*), designed for parents, on the subject of discipline, were presented in Plainfield, Summit, Elizabeth, Cranford, and Linden. The large audiences consisted of members of parent-teacher associations, service clubs, and other organizations. In Plainfield, the plays were jointly presented by the Parents League of the Hartridge School and the society. The Exchange Club itself sponsored the plays in Linden, working coöperatively with members of the society's education committee, who assisted in program planning and in supplying qualified discussion leaders. In the remaining communities, the program was sponsored independently by the society. In recommending competent discussion leaders, the society helped to assure the educational effectiveness of the plays, which depended considerably upon the discussions that followed their presentation. Prominent psychiatrists and experienced psychiatric social workers served as discussion leaders.

In April a seminar on "Child Development" was presented in Cranford, weekly, for a five-week period, to an audience of parents, educators, and other interested individuals. This was conducted by Dr. Raymond H. Gehl, former staff psychiatrist at the Union County Clinic.

Numerous requests for lists of recommended mental-health films have been received by the society during the past months. Therefore, in May, 1950, the education committee established a subcommittee on audio-visual aids, under the leadership of Mrs. Henrik Bode, of Summit. This group, with the coöperation of the National Association for Mental Health, is sponsoring a series of showings of mental-health films on a demonstration basis. Two have already been held and three or more will follow. The films have included *Human Reproduction, Your Children's Sleep,* and *Preface to a Life.* The showings are open to a group of key community personnel on an invitation basis only. The group has included superintendents of schools, principals of private and public schools, parent-teacher-association leaders, and officials of civic, welfare, and educational groups. A skilled discussion leader guides the discussion that follows the showing.

The basic purpose of this new venture is twofold: to acquaint community leaders with the educational possibilities of mental-health films and to help them develop skill in evaluating and selecting both films and discussion leaders in order to make maximum use of this method of education. As a result of this project, a list of recommended films eventually will be drawn up for distribution.

New York

The Nassau County Mental Health Association has proposed a study in two small schools of the effects of a positive mental-health approach through the school over a five-year period. In coöperation with Adelphi College, it plans an intensive training workshop for teachers, concurrent with a program of parent education. Emphasis will be on the dynamics of child development, problems of child personality and guidance, and other mental-health concepts of importance to children.

We note, in the January, 1951, newsletter of the Mental Hygiene Association of Westchester County, that they undertook a project to study the habits of high-school teen-agers in the matter of syndicated advice columns in newspapers and periodicals. The association devised a questionnaire and obtained the coöperation of high schools. The newsletter describes the findings of the study—a study that the society realizes had shortcomings from a scientific psychological point of view. They do feel, however, that it has brought to light considerable evidence of alert, straight thinking on the part of a good many high-school students who may be considered as a fair sample in White Plains High School. It was found that most of the high-school boys and girls read the columns. Apparently, however, they are largely read just for the fun of it or out of curiosity since the opinions expressed of their value were unfavorable by three to one.

North Carolina

We note, in the January, 1951, newsletter of the North Carolina Mental Hygiene Society, that this society is one of sixteen state organizations that have membership in the state legislative council. The council was organized in North Carolina in 1920 by five women's organizations. In 1934 membership was expanded to include representatives of state-wide organizations, with both women and men included in the membership. In 1941 the council became the fifteenth state council to join the National Council on State Legislation.

The state legislative council has a twofold purpose: (1) proposing new social legislation, and (2) safeguarding worth-while legislation already enacted. Each member agency appoints one representative to a study committee, which was organized in 1948. This committee works for two years studying the need for proposed legislation. After particular needs have been defined, they are presented to the total membership of all organizations. If unanimously approved by all member agencies, the state legislative council becomes responsible for sponsoring the passage of specific legislation.

Among the recommendations of the 1951 program of this council is a bill that would authorize the appropriation of $750,000 for con-

structing and equipping a psychiatric unit at the University of North Carolina Medical School, in order to provide facilities for the treatment of selected mental cases and the training of professional personnel; and a bill requesting the sum of $75,000 for each of the years of the biennium 1951–1953, to be used in establishing and maintaining, in the state hospitals, an in-service training program for personnel engaged in the professional care of patients. This bill also requests a similar apportionment each year of $125,000 to be used in adjusting the salaries of professional personnel to the extent necessary to obtain more well-trained professional persons in the state hospitals.

Ohio

The Cleveland Mental Hygiene Association has sent out a notice: "Attention, Taxpayer!" in which it compares the average total time a patient spends until death or discharge in a receiving hospital (31.6 days) as contrasted with a state hospital (675.5 days). It also compares the cost to the state and to the taxpayer of each bed per year in each type of hospital ($3,247 in a receiving hospital versus $638 in a state hospital). The total cost of treating a patient in each type of hospital is $281 in a receiving hospital versus $1,181 in a state hospital, the difference being due to the great difference in length of average stay of each patient. A strong plea is made for citizen backing of a sufficient appropriation to provide a treatment program instead of mere custodial care, thus rehabilitating more patients, reducing overcrowding, and returning citizens to useful living at a time when man power is sorely needed.

Cleveland legislators were invited to tour the state hospital and hear Dr. Crawfis explain budget problems. This tour took place under the auspices of the State Hospital Advisory Committee and the Cleveland Mental Hygiene Association. The Ohio Probate Judges Association sponsored similar tours for legislators on a state-wide basis. The Cleveland Association considers these tours a valuable experience and a sign of growing interest in the plight of Ohio's 33,000 mentally ill, who cannot speak for themselves.

The Montgomery County Mental Hygiene Association held an all-day meeting at the Dayton State Hospital, arranged through the efforts of the Ohio Probate Judges Association with the coöperation of the superintendent of the hospital. The purpose was to have the legislators representing the 13 counties served by the hospital become better acquainted with its work, problems, and needs. The executive secretary of the association participated in the program, in which various community organizations were represented. The society

mentions that it originally initiated meetings of this type over two years ago.

It also mentions that a selected list of references on the mentally retarded is available at its office. The list includes books, pamphlets, and reprints about these handicapped children and offers information on all aspects of care for mentally retarded children.

Included in the society's February newsletter is a brief description of all bills before the state legislature that would further the mental-health program, with pleas for their support. Bills that the association is supporting include a state survey of policies toward the aged; a state survey of programs for sex offenders; the establishment of a separate department of mental hygiene; the establishment of a division on chronic alcoholism; and the establishment of a bureau on mental deficiency within the division of mental hygiene and the provision of financial support to local programs for the mentally deficient. A few other measures are also of interest. One in particular the association feels should be defeated because it removes a special source of funds for the mental-hygiene division's program of education, prevention, and research. The Montgomery County Association has worked with other local and state groups, including the Ohio Mental Hygiene Association, to promote desired action on these bills. It feels that the number-one problem is to get more adequate appropriations for the mental-hygiene division.

Oregon

The Mental Health Association of Oregon has just completed one of its most ambitious undertakings—an investigation and report of the state's three mental institutions. The study is now in the hands of the Oregon Board of Control (made up of the governor, the secretary of state, and the state treasurer) and the recommendations of the study have been mailed to all members of the legislature.

The association feels that the study will be a positive step toward better mental health in the state. The able direction given by Dr. Richard B. Dillehunt, retired dean of the Oregon Medical School and chairman of the study committee, the assistance of some of the most respected lay and professional people in the community, the excellent publicity given the study by the newspapers, plus the reasonable and calmly stated findings and recommendations of the report, lead to the belief that community and legislative action will be forthcoming.

The association has given the following five recommendations top priority:

1. The establishment of an overall administrative program for the state-hospital system and directly related mental-health programs outside the state board of control, either through delegation by the board

or by enactment by the legislature. It mentions several alternate systems that it considers more satisfactory than the present one.

2. The immediate development of programs whereby the state will begin to train needed professional psychiatric personnel. For the most part this can be done by establishing a graduate training program in psychiatry at the University of Oregon.

3. The immediate extension of hospital facilities. It is recommended that another state hospital be built near the metropolitan area of Portland.

4. The immediate appointment of an advisory board made up of persons known to be interested in the care and treatment of the mentally ill. This should be a rotating board, not paid except for actual expenses.

5. The appointment of an interim committee of the legislature to restudy and perhaps revise the code concerning the entire program for the mentally ill. The interim committee should work closely with the advisory board recommended above.

Pennsylvania

The *Pennsylvania Mental Health News,* distributed by the Pennsylvania Citizens Association for Health and Welfare, in its December, 1950, issue, describes the progress of Pennsylvania's mental-health program from 1947 through 1950. It refers to the 1950 Council of State Government's study, *The Mental Health Programs of the Forty-eight States,* and states that the secretary of welfare and the commissioner of mental hygiene will doubtless make a careful study of all the recommendations. It cites particular examples pertinent to Pennsylvania.

Under the joint auspices of the Pennsylvania Citizens Association and the Health and Welfare Council of the Philadelphia area, over 80 civic leaders, public officials, and interested individuals met in Philadelphia on January 26 to discuss the critical problem of care for Philadelphia's mentally ill. The meeting developed from the interest engendered by the publication by Earl Selby, in four of his columns in the *Philadelphia Bulletin,* of facts regarding the desperate situation many Philadelphians face when mental illness occurs in their families.

With limited exceptions, all Philadelphians who need public care for mental illness must seek such care at Philadelphia General Hospital, which acknowledges that it cannot now accept even all cases that are homicidal or suicidal. Poor turnover, occasioned by the fact that the Philadelphia State Hospital will accept only ten patients a week, is blamed for the inadequate care. Philadelphia State Hospital points to its continued overcrowding, despite a multi-million-dollar

construction program, and the tremendous load of "senile" patients.

The result of the meeting was a recommendation to Governor John S. Fine that he appoint a special commission to study the situation and report to the current biennial legislative session. Secretary of Welfare William C. Brown, who was present at the meeting, has urged appointment of the commission in a strongly worded letter to the governor.

A bill was introduced into the House of Representatives on February 12 embodying the recommendations of the Joint State Government Commission for a Mental Health Act of 1951. If passed, this act will replace the Mental Health Act of 1923, and will include provisions from related acts passed both before and since 1923. The Pennsylvania Citizens Association's Mental Health Division has submitted a report recommending a number of changes in the proposed act, although commending the present draft as a great improvement over the law as now on the books. It feels that Pennsylvania's commitment provisions have long been among the best in flexibility and in emphasis on the medical rather than the legal aspect of hospitalization. The Mental Health Act of 1923 was the first in the country to eliminate such terms as "insane" and "feebleminded" from the civil mental-health act.

The Mental Health Committee of the Health and Welfare Council of Philadelphia and vicinity, in coöperation with the Pennsylvania Citizens Association and the Pennsylvania Department of Welfare, is planning a regional mental-health workshop. It will be held at Norristown State Hospital on April 30. The workshop will be an opening gun in the general observance of National Mental Health Week and is being planned by a special subcommittee of the mental-health committee.

The Division on Mental Health of the Pennsylvania Citizens Association reports that each of its sections, except the Southeast, has had two meetings this past fall and that the West Central Section is planning a special mental-health working conference to be held in Altoona, April 5. The Northwest Section is undertaking a survey of facilities and needs in the area. The Lancaster County Mental Hygiene Association and the Montgomery County Mental Hygiene Association have been holding a series of meetings, furnishing mental-health speakers and using mental-health films and plays as a basis for community discussion meetings.

South Carolina

Mrs. Frank, of the National Association, on her southern field trip, met with the president and secretary of the South Carolina Mental and Social Hygiene Society in Charleston. She also met with the

president of the South Carolina Mental Health Foundation and the chairman of the society's division of mental hygiene in Columbia. She was informed that the Mental Health Foundation and the Mental and Social Hygiene Society would be amalgamated in the near future and that the society hoped to have a more active mental-health program.

South Dakota

From correspondence with Mrs. Faith Watson, Secretary of the South Dakota Mental Health Association, we note the enthusiasm and real efforts that she and her husband, Dr. E. S. Watson, president of the association, are putting into the organization's program.

They drove 200 miles to Pierre for the appropriations-committee hearing on the budgets for the four state institutions. They state that on the coldest night of the year, 28 below zero, 30 people, mostly non-members, attended a meeting, which they feel shows great interest. They report that the Yankton Chapter is progressing, Sioux Falls is in the making, and the Black Hills Chapter is continuing its good program. Reports on the White House Conference were given at one of the executive-committee meetings via panel discussion by five or six of the association's members who had attended this conference.

The association received word that House Bill 82, appropriating $8,500 for federal matching in mental health, had been killed in the state senate by 20 to 15, after passing the house unanimously. A series of long-distance calls was made and hurriedly mimeographed material was sent by Dr. and Mrs. Watson to over 600 members of the association. The mimeographed material consisted of one sheet which showed briefly the functions of the mental-health section of the state department of health and described how the state would benefit if the $8,500 of state money were appropriated so that $20,000 of federal money could also be received. A letter was sent to all members of the association, with a penny postal card attached for signature, requesting South Dakota senators to reconsider and pass this bill.

Many telegrams and letters were sent to the legislature, and petitions were circulated in all the principal cities and a number of the small ones. More than 3,000 names were on the petitions and the returned cards, many coming from towns in which the society had no membership and no workers. A committee of 33, members and non-members of the association, 8 of them ministers from 9 cities in the states, held a conference with the governor, and he seemed to be much impressed by the delegation and the elaborate display of names on the petition. A later conference with four senators outlined the strategy to be followed in reviving the issue. After this, eight of the committee, including Dr. Watson, appeared before the appropriations

committee. In this meeting, the fight against federal aid, which had been the keynote of the present legislature, arose, and was ably handled by Reverend George M. Thomas, Congregational minister from Rapid City, who had been chosen as spokesman for the delegation. Word has recently been received from the association that the bill has been passed.

The January, 1951, newsletter of the association pointed out the activities of the local societies and presented summaries of the needs of the institutions. Statements from the board of charities' biennial report, from the institution superintendents, and so on pointed out the real need for more adequate appropriations, all of which were approved by the board of charities and were termed urgent by the association.

Texas

The publication of the Texas Society for Mental Health, *Texas Trends in Mental Health,* (Vol. 7, No. 3, Spring, 1951), focuses on "The Expectional Child." It includes the following articles: *The Exceptional Child—Parents and Our Community; Exceptional Children—Who Are They?; The Texas Legislative Council Studies the Education of Mentally Retarded Children for The Texas Legislature; What is Required of a Teacher for Exceptional Children?; Curriculum Planning for the Exceptional Child; The Case of The Gifted Child; How Parents in a Community Meet the Problems of The Retarded Child; The Use of Scouting in Group Counseling with The Exceptional Child;* and *The Eighteenth Annual Conference of The Texas Society for Mental Health.* We think this material will be of interest to any society or group concerned with this problem.

Washington

The February, 1951, issue of *Mental Health Today,* the news bulletin of the Washington Society for Mental Hygiene, includes a list of bills pertaining to mental health up before the present legislature and describes briefly and pertinently the measures that the society feels should be endorsed.

It also mentions that the Washington Society was one of a dozen health agencies to join six professional organizations in forming a new state health council. The president of the Washington society is on the executive committee of the new organization and the society's other delegate to the council is its executive director, George Ault.

A page and a half in this issue of the bulletin are given to the subjects "The Mental Rejectees—How are they screened?—Where do they go from here?" The opinions of former brigadier general and chief army neuropsychiatrist, William C. Menninger, M.D., are quoted,

and facts and figures are given in detail on information received from the Seattle Armed Forces Induction Station as to the number of acceptances and rejections of draftees. A description of a form that draftees complete is presented as well as the procedures taken if certain questions are checked. The article states that "there is no counseling for neuropsychiatric rejectees. Since they are still civilians, this certainly would seem to be an area for civilian help through reference to an adult psychiatric clinic or, if no such clinic is available—as is the case in Seattle—at least to the Washington Society for Mental Hygiene and its affiliated units."

The society informs us that Mental Recovery, Inc., has completed its second year. The objectives of this organization are: "(1) to provide the opportunity for organized self-help, mutual aid, and group expression for men and women who have been mentally ill, and who upon recovery desire to take an active and constructive part in dealing with the problems of mental illness; (2) to give sympathetic nonpatients the opportunity to aid in this rehabilitation; (3) to enlighten the general public as to the needs and social-civic value of former mental patients; and (4) to aid patients at present in mental hospitals." Most of its work is in providing a social outlet for the members. Occupational therapy has been a part of the program under the direction of Mrs. Robert Jamieson. On the third Monday of each month, she directs the members in leather, felt, and other art work. The first Monday of the month is an educational meeting, with speakers or movies and a discussion period. During the summer months picnics are held at the beaches or in the yards of the members.

This society also reports that the Mental Hygiene Service Guild's present and future projects include: (1) obtaining more furniture for the recreation room at the State Training School for Boys, Chehalis; (2) recreational work with children in the custody of Seattle's juvenile court—reading, finger-painting, and the like; (3) supplying materials for occupational therapy at Rainier State School for the Mentally Deficient; and (4) providing new dresses for girls released from the State Training School for Girls at Grand Mound.

The bulletin cites the activities of the Washington Society's mental-hygiene units and informs us that a new unit is being formed.

Wisconsin

We note, from material sent us from the Milwaukee County Society for Mental Health, that in coöperation with the Wisconsin Congress of Parents and Teachers, the Milwaukee State Teachers College, and the Milwaukee Public Library, it is planning to sponsor a mental-health-education workshop to be held at Milwaukee State Teachers College, the week of June 18–22, 1951.

The five all-day sessions will deal with vital mental-health problems of concern to all age groups. Local specialists in the fields of education, psychology, and psychiatry will serve as consultants and discussion leaders.

The program is being planned for parents, teachers, and leaders in adult and religious education. Leaders in parent-teacher groups will have an opportunity to work out mental-health programs for their schools.

A registration fee of $2.00 will cover the entire program. Advance information can be secured from the Committee for Mental Health Education in the Schools, Chairman, Helen Leslie Dunlap, 1701 East Capitol Drive, Sherwood, Wisconsin.

The society has sent out their "First Call!" for applicants to serve in institutional service units for the coming summer.

It is also continuing the orientation seminars that it held last year for its board of directors and committee chairmen and membership, and for the general membership of the society. These are held on a monthly basis. As examples, the following topics are scheduled: "The Mental Health Programs of the 48 States"; "Problems of the Aged"; "Problems of Alcoholism"; "Cultural Problems in Mental Health"; "Mental Health in Medical Education"; "Mental Health for the Physically Handicapped"; "Sex-Psychopath Problems"; "Youth Problems"; and "Mental Health for the Mentally Retarded."

The Committee on Pastoral Counseling has scheduled the Second Institute on Pastoral Counseling to coincide with Mental Health Week.

We have received a report from Mr. Oeland, Chairman of the Citizens' Public Welfare Association, Madison, Wisconsin, on the importance of a legislative program. He points out the necessity for a strong organization of leading citizens and the support of newspapers, radio stations, and so on, to help in the education of the public to specific needs. He describes the steps he took in working for better legislation, such as personal contacts with the governor and leading members of the senate and house and appearances before the joint finance committee and other committees. Mr. Oeland states:

"We planned and carried out trips to Illinois institutions and persuaded the governor, members of the finance committee, and some of the leaders of both houses to make the trip. They came away from these visits determined to bring about reforms in our own institutions, after seeing the contrast and being convinced mechanical restraint and seclusion were an unnecessary evil.

"During our visits to Illinois mental institutions, the Illinois public-welfare officials volunteered to take groups of attendants and nurses

from other state institutions for a study of their system of non-restraint."

Advantage was taken of this offer by hospital staff from Wisconsin as well as from other states. Mr. Oeland stresses the fact that the governor is quite often the key man to get important measures, such as the mental-health program, through the legislature. He, therefore, kept in touch with the governor, giving him information that might be helpful to him, but being careful not to waste any of his time. Information also was furnished to the leaders of the senate and assembly and a special study was made of any important matter about which they desired information.

Mr. Oeland feels that the mental-hygiene societies should give enthusiastic support to the governors who have expressed their desire for the support of the citizens in carrying through a modern psychiatric treatment and preventive program and concludes with: "Who is in a better position than the mental-hygiene societies to secure this support asked for by the governors? There will be no easy road to success. Hard work, publicity, diplomacy, determination, and persistence will be needed."

CURRENT BIBLIOGRAPHY *

Compiled by

EVA R. HAWKINS

The National Health Library

Abrahamsen, David, M.D. Study of 102 sex offenders at Sing Sing. Federal probation, 14:26–32, September 1950.

Ackerman, Nathan W., M.D. Psychoanalysis and group psychotherapy. Group psychotherapy, 3:204–15, August-December 1950.

Alexander, Franz, M.D. Analysis of the therapeutic factors in psychoanalytic treatment. Psychoanalytic quarterly, 19:482–500, October 1950.

Allerhand, Melvin E., and others. Personality factors in neurodermatitis; a preliminary study. Psychomatic medicine, 12:386–90, November-December 1950.

Alt, Herschel. Indications for mental health planning for children in Israel. American journal of orthopsychiatry, 21:105–23, January 1951.

American psychiatric association—Functions of the Committee on industrial psychiatry. Industrial medicine and surgery, 20:67–68, February 1951.

Appel, Kenneth E., M.D. and Dratman, M.L., M.D. Character—its formation and modification. Journal of the Oklahoma state medical journal, 43: 518–25, December 1950.

Appraising the contribution of the mental hygiene clinic to its community. American journal of orthopsychiatry, 21:74–104, January 1951. Contents: In psychiatric treatment, training, and research, by G. E. Gardner.—In the promotion of mental health, by J. V. Coleman, M.D.—Discussion, by A. Z. Barhash, M.D., and others.

Arieff, Alex J., M.D. Twelve-year résumé in a clinic for epilepsy. Diseases of the nervous system, 12: 19–22, January 1951.

Axline, Virginia M. "Don't ask me why." NEA journal, 40:33–34, January 1951.

Baer, Walter H., M.D. Training programs for psychiatric aides. Welfare bulletin, Illinois department of public welfare, 41:10, 23–24, November 1950.

Bailey, Percival, M.D. and Gibbs, F. A., M.D. The surgical treatment of psychomotor epilepsy. Journal of the American medical association, 145:365–70, February 10, 1951.

Bakwin, Harry, M.D. Feeblemindedness and pseudofeeblemindedness. Journal of pediatrics, 37:271–80, August 1950.

Bakwin, Harry, M.D. Psychologic implications of early child care. American journal of nursing, 51:7–10, January 1951.

Bakwin, Ruth M., M.D. Recent advances in child psychiatry of interest to the pediatrician. Journal of the American medical women's association, 5:492–94, December 1950.

Baldwin, Dorothy S. The psychiatric social worker's approach to mental deficiency in children. Journal of psychiatric social work, 20:60–65, December 1950.

Bane, Frank. Flood tide for mental health. Menninger quarterly, 5:9–12, January 1951.

Bane, Frank. The governors' study on mental hospitals. Mental hygiene, 35:10–13, January 1951.

Barrett, Joseph E., M.D. We can and should do better. "Could you live on $1.54 a day?" Mental health in Virginia, 1:5–8, October 1950.

Baruch, Dorothy W. and Miller, Hyman, M.D. The use of spontaneous drawings in group therapy. American journal of psychotherapy, 5:45–58, January 1951.

Beaman, George B., M.D. Psychiatry in general practice—some aspects of fear. New England journal of medicine, 243:949–52, December 14, 1950.

Beasley, Jane. Group therapy in the field of speech correction. Journal of exceptional children, 17:102–7, January 1951.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Bennett, Abram E., M.D. and others. Experiences with antabuse treatment of alcoholism in a general hospital. Journal of nervous and mental disease, 112:393–400, November 1950.

Bennett, Abram E., M.D. and others. Psychotic reactions during tetraethylthiuramdisulfide (antabuse) therapy. Journal of the American medical association, 145:483–84, February 17, 1951.

Binger, Carl, M.D. Public education in psychiatry. Is it possible? Is it desirable? American journal of psychotherapy, 5:4–15, January 1951.

Bingham, June. What the public thinks of psychiatry. American journal of psychiatry, 107:599–601, February 1951.

Blain, Daniel, M.D. Trends in modern psychiatry. Canadian medical association journal, 64:15–19, January 1951.

Block, Siegfried, M.D. Some remarks about psychotherapy. Medical times, 79:21–28, January 1951.

Bloss, James R., M.D. Causes of fear among obstetric patients. Journal of the American medical association, 144:1358–61, December 16, 1950.

Bonnell, John S. Is faith healing valid today? Pastoral psychology, 1:7–10, January 1951.

Booth, Gotthard. Basic concepts of psychosomatic medicine. Pastoral psychology, 1:11–16, 18, January 1951.

Bowling, R. W. The sex offender and law enforcement. Federal probation, 14:11–16, September 1950.

Bowman, Karl M., M.D., and others. Thyroid function in mental disease, a multiple test survey. Journal of nervous and mental disease, 112:404–24, November 1950.

Bram, Israel, M.D. Psychic factors in obesity; observations in over 1,000 cases. Archives of pediatrics, 67: 543–52, December 1950.

Branham, Vernon C., M.D. Comment on relation of social psychiatry to group psychotherapy. Group psychotherapy, 3:196, August-December 1950.

Braude, Jacob M. The sex offender and the court. Federal probation, 14:17–22, September 1950.

Brickman, William W. Parent education. School and society, 73:117–23, February 24, 1951.

Brugger, Maryan H. The child and his world: Parents and teachers consider the emotional needs of children. Mental health bulletin, Illinois society for mental hygiene, 28:1–8, November-December 1950.

Brunori, Nicola, M.D. General practitioners and psychiatry. American practitioner and digest of treatment, 2:138–45, February 1951.

Buck, McKenzie. Speech therapy in a psychiatric hospital: a report of two cases. Journal of speech and hearing disorders, 15:307–15, December 1950.

Buehler, Mary F. Straitjackets to psychiatry. Welfare bulletin, Illinois department of public welfare, 41:11–12, 20, December 1950.

Bullock, Adeline. Message from Moose Lake. (Inauguration of nonrestraint program at Moose Lake state hospital.) Today's health, 28:27–28, December 1950.

Burch, Lewis J., M.D. What to do for nervous habits. Parents' magazine, 26:40, 103, January 1951.

Burgess, Helen S. Psychiatry and your child. Today's health, 29:26–27, 48, January 1951.

Burlingame, C. Charles, M.D. Psychiatry in 1950. Journal of the American medical association, 144: 1365–68, December 16, 1950.

Buxbaum, Edith. A contribution to the psychoanalytic knowledge of the latency period. Workshop, 1950. American journal of orthopsychiatry, 21:182–98, January 1951.

Caplan, Gerald, M.D. Mental-hygiene work with expectant mothers—A group psychotherapeutic approach. Mental hygiene, 35:41–50, January 1951.

Caplan, Hyman, M.D. Some interview techniques in child psychiatry. Journal of pediatrics, 38:128–40, January 1951.

Case, John R. Station WIOL—Advanced therapy for psychiatric patients. Hospitals, 25:56–57, January 1951.

Cholden, Louis, M.D. The family of the patient. Menninger quarterly, 5:16–19, January 1951.

Clark, Marguerite. The popularization of psychiatry. American journal of psychotherapy, 5:16–23, January 1951.

Clark-Kennedy, Archibald E., M.D. The patient and his disease. Lancet (London), 259:661–67, December 2, 1950; 723–29, December 9, 1950.

Clemmer, Donald. Observations on imprisonment as a source of criminality. Journal of criminal law and criminology, 41:311–19, September-October 1950.

Close, Kathryn. Everybody's business—the young of the nation. Survey, 86:535–40, December 1950.

Coddington, James W. Mental health survey producing vital data. Arkansas health bulletin, Arkansas state board of health, 7:3, 6, December 1950.

Cohen, Newman, M.D. Rôle of the psychiatrist in the rehabilitation of the disabled veteran. Diseases of the nervous system, 12:3–9, January 1951.

Coleman, Jules V., M.D. Psychiatric service in relation to public health activities. Milbank memorial fund quarterly, 29:31–40, January 1951.

Coleman, Lester L., M.D. If your child faces surgery. Parents' magazine, 26:34, 75, January 1951.

Conroy, Virginia. To walk alone; one woman's story of psychoanalysis. Today's health, 29:22, 50–51, January 1951.

Cotton, John M., M.D. Group structure and group psychotherapy. Group psychotherapy, 3:216–17, August-December 1950.

Cottrell, Leonard S., Jr. Some neglected problems in social psychology. American sociological review, 15: 705–12, December 1950.

Crain, Kenneth C. The Pennsylvania hospital—Department of mental and nervous diseases. Hospital management, 71:112, 118, January 1951.

Crawfis, Ewing H., M.D. Geriatrics and mental health. Ohio's health, Ohio department of health, 2:13–15, December 1950.

Crawfis, Ewing H., M.D. The physician and privileged communications as they relate to mental state. Ohio state medical journal, 46:1082–85, November 1950.

Cross, Helen R. One world—child size. National parent-teacher, 45:26–28, January 1951.

Davies, Stanley P. The family agency's contribution to mental health. Social casework, 32:61–66, February 1951.

Davis, Allison. Ability and survival. Survey, 87:60–63, February 1951.

Davis, Allison. Socio-economic influences upon children's learning. Understanding the child, 20:10–16, January 1951.

Debré, Robert. The International children's centre. International children's centre courrier, 1:21–34, November 1950.

Deschin, Celia S. How can social work make a major contribution to psychiatric theory? Journal of psychiatric social work, 20:43–52, December 1950.

Devereux, George. Status, socialization, and interpersonal relations of Mohave children. Psychiatry, 13: 489–502, November 1950.

Doll, Edgar A. Mental evaluation of children with expressive handicaps. American journal of orthopsychiatry, 21:148–54, January 1951.

Dorsey, John M., M.D. A psychotherapeutic approach to the problem of hostility; with specific application to the problem of racial prejudice. Social forces, 29:197–206, December 1950.

Dreskin, Nathan. One in ten? Don't believe it! Health, Health league of Canada, p. 10, 24, 28, November-December 1950.

Duncan, Charles H., M.D. and others. Life situations, emotions, and exercise tolerance. Psychosomatic medicine, 13:36–50, January-February 1951.

Dybwad, Gunnar. Child care in Germany. Survey, 87:110–14, March 1951.

Education versus indoctrination in psychiatric teaching. American journal of psychiatry, 107:633–34, February 1951.

Egan, John R., M.D., and others. A study of neuropsychiatric rejectees. Journal of the American medical association, 145:466–68, February 17, 1951.

Emotional health. Health bulletin for teachers, 22:1–4, November 1950.

Enneis, James M. A note on the organization of the St. Elizabeths hospital psychodrama program. Group psychotherapy, 3:253–55, August-December 1950.

Fantl, Kurt, M.D. Psychiatric aspects of civilian defense. American journal of psychiatry, 107:488–92, January 1951.

Fechner, A. H., M.D. and Parke, J. H. The volunteer worker and the psychiatric hospital. American journal of psychiatry, 107:602–6, February 1951.

Fielding, Benjamin B. Attitudes and aspects of adjustment of the orthopedically handicapped woman. Journal of exceptional children, 17:78–81, 86, December 1950.

Finch, Mildred S. Tips for stepmothers. Parents' magazine, 26:37, 70–71, January 1951.

Foote, Nelson N. Identification as the basis for a theory of motivation. American sociological review, 16:14–21, February 1951.

"For every child—A fair chance for a healthy personality." California's health, California state department of public health, 8:73–75, November 30, 1950.

Forster, Francis M., M.D. Therapy in psychomotor epilepsy. Journal of the American medical association, 145:211–15, January 27, 1951.

Fox, William W., M.D. and Reed, E. H. A modern unit for infant mental patients. Hospitals, 24:40–44, December 1950.

Frank, Jerome D., M.D. Group psychotherapy in relation to research. Group psychotherapy, 3:197–203, August-December 1950.

Frank, Lawrence K. Newer approaches to sex education. Pastoral psychology, 1:19–24, January 1951.

Franklin, Adele. Having fun together. National parent-teacher, 45:27–29, December 1950.

Freeman, M. J. Reinforcement therapy: A re-evaluation of the concept of "insight" in psychotherapy. American journal of psychotherapy, 5:32–37, January 1951.

Fremont-Smith, Frank. Mental health, education, and international cooperation. Pastoral psychology, 1:13–16, December 1950.

Freund, Julius D., M.D. Electronarcosis (as an adjunct to psychotherapy). Diseases of the nervous system, 11:332–35, November 1950.

Fromm, Erich. Dianetics; editorial note. Psychosomatic medicine, 12: 343–44, November-December 1950.

Froscher, Hazel B. An example of collaborative research in casework. Social work journal, 32:19–23, January 1951.

Galdston, Iago, M.D. Integrative psychiatry. Bulletin of the New York academy of medicine, 26:736–56, November 1950.

Gardner, Yvelin. The National committee on alcoholism; annual report —1950. Quarterly journal of studies on alcohol, 11:567–85, December 1950.

Garvin, John S., M.D. Medical treatment of epilepsy today. Illinois medical journal, 98:344–49, December 1950.

Gehman, Irene E. How adolescents view their teachers. Understanding the child, 20:20–22, January 1951.

Geller, Joseph J., M.D. Current status of group psychotherapy practices in the state hospitals for mental disease. Group psychotherapy, 3:231–40, August-December 1950.

Glasser, Melvin A. Fact-finding for the White House conference on children and youth. Social security bulletin, 13:15–16, November 1950.

Godek, Isabelle. Integration of psychological components into pediatrics —up to the age of two. Canadian nurse, 47:22–28, January 1951.

Godek, Isabelle. The "spoiled child." A child needs love most when he appears to deserve it the least. American journal of nursing, 50:773–74, December 1950.

Golden, Janet M. and Mensh, I. N. Some factors in therapeutic success. Journal of psychiatric social work, 20: 68–73, December 1950.

Goldman, Rose. The psychiatric social worker's treatment rôle. Journal of psychiatric social work, 20:65–68, December 1950.

Gordon, Faith F., M.D. Guidance center children. Mental health in Virginia, 1:12–15, October 1950.

Gorsline, Ethlyn P. 38 spoiled apples. Today's health, 29:36–37, 64–66, January 1951.

Gottlieb, Jacques S., M.D. Health springs from both—body and mind. National parent-teacher, 45:4–6, January 1951.

Greenacre, Phyllis, M.D. General problems of acting out. Psychoanalytic quarterly, 19:455–67, October 1950.

Greenhill, Maurice H., M.D. and others. Recent developments in the teaching of comprehensive medicine. North Carolina medical journal, 11:615–19, November 1950.

Group dynamics. American journal of orthopsychiatry, 21:1–35, January 1951.

Contents: "Social role" and total personality, by N. W. Ackerman, M.D.—Group dynamics and personality dynamics, by Ronald Lippitt.—Discussion, by David Shakow.

Haas, Alfred B. The therapeutic value of hymns. Pastoral psychology, 1: 39–42, December 1950.

Ham, George C., M.D. and others. A psychosomatic theory of thyrotoxicosis. Psychosomatic medicine, 13: 18–35, January-February 1951.

Hamilton, Samuel W., M.D. and Corcoran, M.E. Planning a mental hospital of fifteen hundred beds. Diseases of the nervous system, 11: 373–80, December 1950.

Harris, Irving D., M.D. Mood, anger and somatic dysfunction. Journal of nervous and mental disease, 113: 152–58, February 1951.

Hartwell, Samuel W., M.D. and others. The Michigan picture test: diagnostic and therapeutic possibilities of a new projective test in child guidance. American journal of orthopsychiatry, 21:124–37, January 1951.

Heady, Eleanor M. The public health nurse and mental hygiene. Canadian nurse, 47:37–43, January 1951.

Henry, Jules and Warson, Samuel, M.D. Family structure and psychic development. American journal of orthopsychiatry, 21:59–73, January 1951.

Herzog, Elizabeth G. What social casework wants of social science research. American sociological review, 16:68–73, February 1951.

Hill, Gerald, M.D. and Silver, A. G., M.D. Psychodynamic and esthetic motivations for plastic surgery. Psychosomatic medicine, 12:345–55, November-December 1950.

Hiltner, Seward. Concentration in counseling. Pastoral psychology, 1: 26–30, December 1950.

Hiltner, Seward. Empathy in counseling. Pastoral psychology, 1:25–28, 30, January 1951.

Himler, Leonard E., M.D. Round table on industrial psychiatry. Conducted by the Committee on industrial psychiatry of the American psychiatric association. Industrial medicine and surgery, 20:65–67, February 1951.

Hoch, Paul H., M.D. Experimentally produced psychoses. American journal of psychiatry, 107:607–11, February 1951.

Hohman, Leslie B., M.D. Medical education in psychiatry. A proposal to raise the standards of psychiatric treatment in North Carolina. North Carolina medical journal, 11:619–21, November 1950.

Hollis, Florence. The relationship between psychosocial diagnosis and treatment. Social casework, 32:67–74, February 1951.

Horney, Karen. The search for glory. Pastoral psychology, 1:31–38, December 1950.

Howe, Hubert S., M.D. Progress in neurology and psychiatry during the first half of the twentieth century. New York state journal of medicine, 51:96–102, January 1, 1951.

Hulse, Wilfred C., M.D. Group psychotherapy and the First international congress of psychiatry, Paris, September 1950. Group psychotherapy, 3:250–52, August-December 1950.

Hulse, Wilfred C., M.D. and Lowinger, Louis. Understanding the alcoholic. GP, American academy of general practice, 3:35–40, January 1951.

Hunter, Harriot, M.D. and Lyon, J. M., M.D. Clinic H: Haven for hypochondriacs. American practitioner and digest of treatment, 2:67–69, January 1951.

Hyroop, Muriel, M.D. The factor of omnipotence in the development of paranoid reactions. American journal of psychotherapy, 5:38–44, January 1951.

Invalidings due to psychotic disorders, 1941–1949. Statistics of navy medicine, U. S. Navy department, Bureau of medicine and surgery, 7:5–6, January 1951.

Jackson, Edith B., M.D. Pediatric and psychiatric aspects of the Yale rooming-in project. Child-family digest, 3:25–35, November 1950.

Johnson, G. Orville and Kirk, S. A. Are mentally handicapped children segregated in the regular grades. Journal of exceptional children, 17:65–68, 87–88, December 1950.

Johnson, Wendell. The rehabilitation of the stutterer. Illinois medical journal, 98:341–43, December 1950.

Johnston, McClain, M.D. An experiment in group psychotherapy with the narcotic addict. American journal of psychotherapy, 5:24–31, January 1951.

Jolowicz, Ernst, M.D. The Brunhild complex. American journal of psychotherapy, 4:610–26, October 1950.

Jones, Granville L., M.D. Are these your neighbors? "They are not so very different from you and me." Mental health in Virginia, 1:8–12, October 1950.

Kanzer, Mark, M.D. The œdipus trilogy. Psychoanalytic quarterly, 19: 561–72, October 1950.

Katz, Julius, M.D. Tuberculosis control in New York state mental institutions. Health news, New York state department of health, 27:10–14, December 1950.

Kawin, Ethel. Playthings and play therapy. National parent-teacher, 45:14–16, December 1950.

Kelley, J. Whitney, M.D. and Bath, F. J. Better psychiatric care for Omaha. Hospital progress, 32:52–53, 55, February 1951.

Kepecs, Joseph G., M.D. and others. Atopic dermatitis; a clinical psychiatric study. Psychosomatic medicine, 13:1–9, January-February 1951.

Kepecs, Joseph G., M.D. and others. Relationship between certain emotional states and exudation into the skin. Psychosomatic medicine, 13: 10–17, January-February 1951.

Kew, Clifton E. and Kew, C. J. Group psychotherapy in a church setting. Pastoral psychology, 1:31–37, January 1951.

Kinross-Wright, Vernon, M.D. The rediscovery of psychosomatic medicine. North Carolina medical journal, 11:621–26, November 1950.

Kirkham, Juanita and Thompson, G. N. The relationship between practicing

psychiatrist and psychiatric social worker. Mental hygiene, 35:104–17, January 1951.

Kline, Carl L., M.D. Suicide; implications for the general medical man. Wisconsin medical journal, 49:1111–1113, December 1950.

Kohl, Richard N., M.D. Administrative aspects of a teaching hospital. American journal of psychiatry, 107:481–87, January 1951.

Koontz, Amos R., M.D. Psychiatry in the Korean war. Military surgeon, 107:444–45, December 1950.

Kris, Ernst. On preconscious mental processes. Psychoanalytic quarterly, 19:540–60, October 1950.

Kubie, Lawrence S., M.D. The neurotic potential, the neurotic process, and the neurotic state. United States armed forces medical journal, 2:1–12, January 1951.

LaBarre, Weston. Appraising today's pressures on family living. Social casework, 32:51–57, February 1951.

Landes, Ruth and Zborowski, Mark. Hypotheses concerning the Eastern European Jewish family. Psychiatry, 13:447–64, November 1950.

Laughlin, Henry P., M.D. and Hall, Milton. Psychiatry for executives. An experiment in the use of group analysis to improve relationships in an organization. American journal of psychiatry, 107:493–97, January 1951.

Lehnert, Bettina. The use of case material in supervision. American journal of orthopsychiatry, 21:54–58, January 1951.

Lewis, Harold. For fathers only. Child-family digest, 3:89–91, November 1950.

Loewenstein, Rudolph M., M.D. Ego development and psychoanalytic technique. American journal of psychiatry, 107:617–22, February 1951.

Lowenfeld, Margaret. A combined approach to the study of treatment of disturbed children. As carried out at the Institute of child psychology, in London, England. American journal of psychotherapy, 4:627–42, October 1950.

Lurie, Harry L. How much social welfare can we afford? Social service review, 24:469–76, December 1950.

Macalpine, Ida, M.D. The development of the transference. Psychoanalytic quarterly, 19:501–39, October 1950.

McAtee, Ott B., M.D. The establishment and function of an industrial mental hygiene service. American journal of psychiatry, 107:623–27, February 1951.

McCarthy, Raymond G. Group therapy in alcoholism. Transcriptions of a series of sessions recorded in an outpatient clinic; VI. Seventh session. Quarterly journal of studies on alcohol, 11:630–53, December 1950.

McIntosh, Millicent C. Education for maternity. Child-family digest, 3:74–77, November 1950.

Mackay, Betsy M. Why won't Tommy eat? Health, Health league of Canada, p. 12, 27, 32, November-December 1950.

McLachlan, D. Gilmour and Falconer, M. A. Prefrontal leucotomy (lobotomy). A report on 65 cases. New Zealand medical journal, 49:522–30, October 1950.

MacNiel, Douglas. Health department responsibility in a mental health program. Public health news, New Jersey state department of health, 31:366–68, December 1950.

Manson, Morse P. Motivations in the rehabilitation of paraplegics. Archives of neurology and psychiatry, 65:34–38, January 1951.

Marañon, Gregorio, M.D. The psychology of gesture. Journal of nervous and mental disease, 112:469–97, December 1950.

Marino, Lee J. Organizing the parents of mentally retarded children for participation in the mental-health program. Mental hygiene, 35:14–18, January 1951.

Martens, Elise H. Toward life adjustment through "special education." School life, 33:52–54, January 1951.

Mayo, Leonard W. Putting our present knowledge to work. Social work journal, 32:4–8, 33, January 1951.

Mead, Margaret. The impact of culture on personality development in the United States today. Understanding the child, 20:17–18, January 1951.

Meerloo, Joost A. M., M.D. The crime of menticide. American journal of psychiatry, 107:594–98, February 1951.

Meiers, Joseph, M.D. Thoughts on recent advances in group psychotherapy (1945–50). Group psychotherapy, 3:241–45, August-December 1950.

Menninger, Karl, M.D. How "human" are we? Menninger quarterly, 5:4–8, January 1951.

Mental hygiene and public health. Chronicle of the World health organization, 4:362–66, December 1950.

Mental, psychoneurotic, and personality disorders. Statistics of navy medicine, 6:4–7, December 1950.

Michal-Smith, Harold. Personality training in vocational education for the retarded child. Journal of exceptional children, 17:108–10, January 1951.

Midcentury White house conference on children and youth. . . A special section. Survey, 87:17–32, January 1951.

Contents: Youth in today's world: Conference report, by Kathryn Close. —Moving ahead, by M. A. Glasser. —What bends the twig? by Marion Robinson.—Gist of the recommendations—Pledge to children.

Middlewood, Esther L. Mental health films in community education. American journal of orthopsychiatry, 21:47–53, January 1951.

Miller, Emanuel, M.D. Constitution—mental disease and psychoanalysis. Eugenics review, 42:202–8, January 1951.

Milliken, Rhoda J. The sex offender's victim. Federal probation, 14:22–26, September 1950.

Montagu, Ashley. Statement on race. Pastoral psychology, 1:9–12, December 1950.

Moore, Merrill, M.D. The need for psychiatry in a municipal general hospital. New England journal of medicine, 244:135–36, January 25, 1951.

Moreno, Jacob L., M.D. The ascendance of group psychotherapy and the declining influence of psychoanalysis. Group psychotherapy, 3:121–25, August-December 1950.

Moreno, Jacob L., M.D. Cradle of group psychotherapy; its twentieth anniversary within the American psychiatric association. Group psychotherapy, 3:126–41, August-December 1950.

Moreno, Jacob L., M.D. Group psychotherapy, therapy and practice. Recommendations presented at the A.P.A. Philadelphia conference on group method (June 1932). Group psychotherapy, 3:142–88, August-December 1950.

Moreno, Jacob L., M.D. Note as to the possible meaning of group psychotherapy for the people of the United States. Group psychotherapy, 3:256–57, August-December 1950.

Morrissey, Alice B. Psychosocial and spiritual factors in rehabilitation. American journal of nursing, 50:763–66, December 1950.

Mowrer, Ernest R. and Mowrer, Harriet. The social psychology of marriage. American sociological review, 16:27–36, February 1951.

Mullahy, Patrick. A philosophy of personality. Psychiatry, 13:417–37, November 1950.

Mullins, Claud. Psychiatry in the criminal courts. Federal probation, 14:37–45, September 1950.

Muncie, Wendell, M.D. The therapeutic situation as it concerns the family with special reference to the other marital partner. American journal of psychotherapy, 4:595–609, October 1950.

Murray, Henry A., M.D. Uses of the Thematic apperception test. American journal of psychiatry, 107:577–81, February 1951.

Myerson, David J., M.D. Present medical approach to alcoholism with special reference to "antabuse." New Hampshire health news, State department of health, 28:111–15, December 1950.

The national mental health program, 1947–1950. American journal of psychiatry, 107:630–32, February 1951.

Neubauer, Peter B., M.D. and Steinert, Joseph. The significance for social workers of the multidiscipline approach to child development. Social service review, 24:459–68, December 1950.

Neville, Wesley L. Admission to mental institutions. Ohio state medical journal, 46:1210–1213, December 1950.

Newton, Niles R. The relationship between infant feeding experience and later behavior. Journal of pediatrics, 38:28–40, January 1951.

Newton, Niles R. Why I weaned my second baby late. Child-family digest, 3:60–62, November 1950.

Nicholson, Margaret M., M.D. Juvenile delinquency. Journal of the American medical association, 144:1538–40, December 30, 1950.

Noble, Douglas, M.D. A study of dreams in schizophrenia and allied states. American journal of psychiatry, 107:612–16, February 1951.

Norbury, Frank G., M.D. Medical problems in psychiatric patients. Illinois medical journal, 98:289–91, November 1950.

Norris, John L., M.D. Alcoholism in industry. Quarterly journal of studies on alcohol, 11:562–66, December 1950.

Norton, Irene M. How an understanding of cultures can aid the day care center. Understanding the child, 20: 23–30, January 1951. (Continued from October 1950 issue.)

Novak, Benjamin J. Start that guidance program slowly—on a sound,

well-rooted basis. Nation's schools, 47:52–54, February 1951.

Nye, Ivan. Adolescent-parent adjustment—rurality as a variable. Rural sociology, 15:334–39, December 1950.

Nye, Kenneth E. Faith for a lifetime. National parent-teacher, 45: 8–10, December 1950.

Oates, Wayne E. The diagnostic use of the Bible. Pastoral psychology, 1:43–46, December 1950.

Oeser, O. A. The conditions of civilized living and the problems of mental health. Medical journal of Australia (Sydney), v. 2, 37th year: 845–50, December 9, 1950; 881–86, December 16, 1950.

Overstreet, Bonaro W. Lots of people are human. National parent-teacher, 45:24–26, December 1950; 10–12, January 1951. (Continued from November issue.)

Parker, George H., Jr. Will psychiatry aid evangelism? Pastoral psychology, 1:38–43, January 1951.

Partridge, Maurice. One operation cures three people; effect of prefrontal leukotomy on a case of folie à deux et demie. Archives of neurology and psychiatry, 64:792–96, December 1950.

Perk, David, M.D. Morale. Mental hygiene, 35:19–40, January 1951.

Pettit, Manson B., M.D. Socio-economic aspects of alcoholism. Quarterly review of psychiatry and neurology, 5:265–71, October 1950.

Pinneau, Samuel R. A critique on the articles by Margaret Ribble. Child development, 21:203–28, December 1950.

Pleasants, Edward N., M.D., and others. The rôle of psychiatric institutions in the teaching of psychiatry. North Carolina medical journal, 11:603–5, November 1950.

Podolsky Edward, M.D. The maladjusted child. Archives of pediatrics, 68:28–32, January 1951.

Pollak, Otto. Relationships between social science and child guidance practice. American sociological review, 16:61–67, February 1951.

Poole, Florence. The social worker's contribution to the problems of the classroom teacher. Journal of exceptional children, 17:73–77, 87, December 1950.

Portis, Sidney A., M.D., Zitman, I. H., M.D. and Lawrence, C. H., M.D. Exhaustion in the young business executive. Journal of the American medical association, 144:1162–66, December 2, 1950.

Prados, Miguel, M.D. The use of films in psychotherapy. American journal of orthopsychiatry, 21:36–46, January 1951.

Rado, Sandor, M.D. Psychodynamics of depression from the etiologic point of view. Psychosomatic medicine, 13:51–55, January-February 1951.

Randall, Harriett B., M.D. The program for epileptic children in Los Angeles city schools. Medical woman's journal, 57:22–25, December 1950.

Rank, Beata and Kaplan, Samuel, M.D. A case of pseudoschizophrenia in a child. Workshop, 1950. American journal of orthopsychiatry, 21:155–81, January 1951.

Ranson, Stephen W., M.D. Psychiatric treatment in combat areas. United States armed forces medical journal, 1:1379–97, December 1950.

Rautman, Arthur L. The mental hygiene of a visit home. Mental hygiene, 35:51–68, January 1951.

Redlich, Frederick C., M.D. and others. Narcoanalysis and truth. American journal of psychiatry, 107:586–93, February 1951.

Rees, John R., M.D. A task for everyone. Mental health in Virginia, 1:1–4, October 1950.

Regardie, Francis I. Experimentally induced dreams as psychotherapeutic aids. American journal of psychotherapy, 4:643–50, October 1950.

Reiner, Elliot R., M.D. and Sands, S. L., M.D. Lobotomy and psychopathology. Archives of neurology and psychiatry, 65:48–53, January 1951

Review of psychiatric progress 1950. American journal of psychiatry, 107: 503–47, January 1951.

Contents: Heredity and eugenics, by F. J. Kallmann, M.D.—Neuropathology, endocrinology, and biochemistry, by O. R. Langworthy, M.D. —Electroencephalography, by W. T. Liberson, M.D.—Psychometrics, by S. G. Estes.—General clinical psychiatry, psychosomatic medicine, psychotherapy, and group therapy, by P. H. Hoch, M.D. and N. D. C. Lewis, M.D.—Physiological treatment, by Joseph Wortis, M.D.—Psychosurgery, by Walter Freeman, M.D.—Child psychiatry, mental deficiency, by Leo Kanner, M.D.—Mental hygiene in education, by W. C. Ryan.—Neurosyphilis, by A. S. Rose, M.D. and V. P. Perlo, M.D.—Alcohol. Geriatrics, by K. M. Bowman, M.D.—Epilepsy, by C. W. Watson, M.D.—Psychiatric nursing, by M. E. Corcoran.—Occupational therapy, by L. F. Woolley, M.D.—Psychiatric social work, by H. B. Crutcher.—Outpatient mental clinics and family care, by H. B. Lang, M.B.—Administrative and

forensic psychiatry, by Winfred Overholser, M.D.—Military psychiatry, by C. S. Drayer, M.D.—Psychiatric education, by F. G. Ebaugh, M.D. and J. J. O'Hearne, M.D.

Revitch, Eugene, M.D. The concept of psychopathic personality. Diseases of the nervous system, 11:369–72, December 1950.

Riese, Hertha, M.D. Educational therapy: a new approach in child guidance. Psychiatry, 13:465–88, November 1950.

Roche, Philip Q., M.D. Sexual deviations. Federal probation, 14:3–11, September 1950.

Rogers, Carl R. A current formulation of client-centered therapy. Social service review, 24:442–50, December 1950.

Roosevelt, Eleanor, and others. Prejudice. Pastoral psychology, 1:17–21, December 1950.

Root, Oren. Basic aims of the National Association for Mental Health. Mental hygiene, 35:1–4, January 1951.

Rosen, Victor H., M.D. The rôle of denial in acute post-operative affective reactions following removal of body parts. Psychosomatic medicine, 12:356–61, November-December 1950.

Ruja, David H. and Ruja, Harry. Mental hygiene in adult education. School and society, 73:17–19, January 13, 1951.

Salsman, Lillian V. Nurse-patient relationships in psychiatric nursing. Mental hygiene news, New York state department of mental hygiene, 21: 5, November 1950.

Saslow, George, M.D. Emotional problems of the chronically ill. GP, American academy of general practice, 2:63–67, December 1950.

Scheidlinger, Lucy P. and Scheidlinger, Saul. When you don't have to worry. Parents' magazine, 26:44–46, 86, January 1951.

Schmideberg, Melitta, M.D. Infant memories and constructions. Psychoanalytic quarterly, 19:468–81, October 1950.

Schmideberg, Melitta, M.D. Just out of prison. Focus, 30:1–8, January 1951.

Schwartz, Morris S. and Stanton, A. H., M.D. A social psychological study of incontinence. Psychiatry, 13: 399–416, November 1950.

Senn, Milton J. E., M.D. After the Midcentury White House conference —what? The Child, 15:81–86, December 1950.

Senn, Milton J. E., M.D. The contribution of psychiatry to child health services. American journal of orthopsychiatry, 21:138–47, January 1951.

Shaskan, Donald A., M.D., Conrad, D. C., and Grant, J. D. Prediction of behavior in group psychotherapy from Rorschach protocols (preliminary report). Group psychotherapy, 3:218–30, August-December 1950.

Shorvon, Hyam J., M. B., and others. Psychological treatment in skin disorders, British medical journal (London), 1300–1304, December 9, 1950.

Simburg, Earl J., M.D. Must our children be neurotic? Mental hygiene, 35:96–103, January 1951.

Smith, Jackson A., M.D., and others. The use of a modified Thematic Apperception Test in a neuropsychiatric clinic in a general hospital. American journal of psychiatry, 107:498–500, January 1951.

Smith, M. Brewster. Optima of mental health: a general frame of reference. Psychiatry, 13:503–10, November 1950.

Smith, M. Elizabeth Reichert. Preparing the student for the psychiatric affiliation. American journal of nursing, 51:47–49, January 1951.

Snyder, Ross. A theory of group dynamics. Religious education, 46:39–43, January-February 1951.

Sommer, Conrad, M.D. Psychoanalytically oriented institutional treatment of children. Diseases of the nervous system, 11:336–39, November 1950.

Spock, Benjamin, M.D. Healthy personalities—what we know about them in children. Minnesota welfare, Minnesota state division of social welfare, 6:8–14, January 1951.

Spock, Benjamin, M.D. What we know about the development of healthy personalities in children. Understanding the child, 20:2–9, January 1951.

Standish, Christopher T., Mann, James, and Menzer, Doris. Some aspects of the psychopathology of schizophrenia; implications in treatment. Psychiatry, 13:439–45, November 1950.

Steinfeld, Julius I., M.D. Acidosis and its therapeutic value in the treatment of psychotics; a preliminary report. Journal of the American medical association, 145:226–27, January 27, 1951.

Stendler, Celia B. and Young, Norman. The impact of beginning first grade upon socialization as reported by mothers. Child development, 21:241–60, December 1950.

Stevenson, George S., M.D. The mental-health program in perspective. Mental hygiene, 35:5–9, January 1951.

Stewart, I. McD. G., M.D. Coronary disease and modern stress. Lancet (London), 259:867–70, December 23, 1950.

Stone, Simon, M.D. Evaluation of vitamin E therapy in psychiatric disorders. Diseases of the nervous system, 11:355–61, December 1950.

Stott, D. H. Study of delinquency. Lancet (London), 259:601-4, November 25, 1950.

Studt, Elliot. Staff guidance in a detention home. Focus, 30:12–17, January 1951.

Sutherland, Edwin H. Critique of Sheldon's *Varieties of delinquent youth.* American sociological review, 16:10–13, February 1951.

Sutherland, Edwin H., and others. Personality traits and the alcoholic. A critique of existing studies. Quarterly journal of studies on alcohol, 11:547–61, December 1950.

Sutton, Virginia. Human relations in Tazewell. Mental health in Virginia, 1:21–23, October 1950.

Tappan, Paul W. Sex offender laws and their administration. Federal probation, 14:32–37, September 1950.

Taylor, Grant, M.D. and Kinross-Wright, Vernon. The teaching of neurology and psychiatry in pediatric medicine in North Carolina. North Carolina medical journal, 11: 612–15, November 1950.

Thomas, Dorothy V. The relationship between diagnostic service and short-contact cases. Social casework, 32: 74–81, February 1951.

Thorner, Isidor. German words, German personality, and Protestantism again. A rejoinder. Psychiatry, 13: 511–14, November 1950.

Tilkin, Leonard, M.D. Narcosynthesis —an invaluable psychiatric technique. Illinois medical journal, 99:85–86, February 1951.

Timm, Oren K. and Davis, J. E. The modification of activities as a treatment aim. Mental hygiene, 35:69–87, January 1951.

Torrence, Paul. Getting mental-hygiene practices into action through a college class. Mental hygiene, 35: 88–95, January 1951.

Toward maturity: A mid-century challenge. We grow in understanding others. Childhood education, 27: 151–83, December 1950.

Toward maturity: A mid-century challenge. We develop discipline for freedom. Childhood education, 27: 198–230, January 1951.

Toward maturity: A mid-century challenge. We improve communication. Childhood education, 27:247–81, February 1951.

Towle, Charlotte. Client-centered case work. Social service review, 24:451–58, December 1950.

Towle, Charlotte. Reinforcing family security today. Social casework, 32:57–61, February 1951.

Tredgold, R. F., M.D. Mental health in industry. Bulletin of the World federation for mental health, 2:5–9, October 1950.

Tucker, Walter I., M.D. Psychiatric factors in essential hypertension. II. Follow-up study of 74 cases. New England journal of medicine, 243: 211–15, August 10, 1950.

Turnbladh, Will C. More about youth authority concepts. Focus, 30:23–25, January 1951.

Twitchell-Allen, Doris. Round table on psychodrama of the American psychological association meeting, State College, Pennsylvania. Group psychotherapy, 3:246–49, August-December 1950.

Tyhurst, Libuse, M.D. Displacement and migration; a study in social psychiatry. American journal of psychiatry, 107:561–68, February 1951.

Tyler, Joe E., M.D. Goals in psychotherapy. Journal of the Oklahoma state medical association, 43:526–28, December 1950.

Tyler, Stanley H., M.D. On the nature of private practice and the need for psychotherapy. American practitioner and digest of treatment, 1:1303–1308, December 1950.

Tyson, Robert. Current mental hygiene practice. An inventory of basic teachings. Journal of clinical psychology, 7:1–94, January 1951, Monograph supplement.

U. S. National institute of mental health. Patients in public institutions for mental defectives and epileptics: 1948. Mental health statistics-Current reports, National institute of mental health, Series IMH-B51, No. 1: p. 1–18, December 1950.

Vold, George B. Edwin Hardin Sutherland: sociological criminologist. American sociological review, 16: 3–9, February 1951.

Wassersug, Joseph D., M.D. and McLaughlin, W. F., M.D. Tuberculosis in mental hospitals. Journal of nervous and mental disease, 113: 115–26, February 1951.

Wattenberg, William W. and Balistrieri, J. J. Gang membership and juvenile misconduct. American sociological review, 15:744–52, December 1950.

White, William A., M.D. Comments on Moreno's "Psychological organization of groups in the community" (1933). Group psychotherapy, 3: 189–95, August-December 1950.
(From Proceedings of the American association on mental deficiency, 1933.)

White house conference on children and youth, 1950. The making of a healthy personality. Highlights from the fact-finding report to the Midcentury White House Conference on children and youth. The Child, 15:90–95, January 1951.

White house conference on children and youth, 1950. Pledge to children. Social work journal, 32:24–25, January 1951.

White house conference on children and youth, 1950. Recommendations. Social security bulletin, 14:10–14, February 1951.

Wilson, Adrian and Williams, P. R. Psychopathic unit for short-term care provides institutional care in un-institutional surroundings. Modern hospital, 76:45–48, January 1951.

Wiltrakis, George A., M.D. Overcrowding and understaffing your mental hospitals. Welfare bulletin, Illinois department of public welfare, 41:13, November 1950.

Wittson, Cecil L., M.D. and Hunt, W. A. The predictive value of the brief psychiatric interview. American journal of psychiatry, 107:582–85, February 1951.

Wolf, Anna W. M. Discipline—the rôle of punishment and reward. National parent-teacher, 45:11–13, December 1950.

Wolf, Stewart, M.D. and Wolff, H. G., M.D. Notes on a symposium: the internist as a psychiatrist. Annals of internal medicine, 34:212–16, January 1951.

Wolfson, Beatrice N. Emotional problems of the intellectually exceptional child. Connecticut health bulletin, Connecticut state department of health, 64:335–40, December 1950.

World federation of mental health. Teachings of dynamic psychiatry and anthropology. Child-family digest, 3:19–24, November 1950.

Young, Kimball. Social psychology and social casework. American sociological review, 16:54–61, February 1951.

Zilboorg, Gregory, M.D. Authority and leadership. Bulletin of the World federation for mental health, 2:13–17, October 1950.

Zubin, Joseph. Objective evaluation of personality tests. American journal of psychiatry, 107:569–76, February 1951.